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Hybridisation – A continuous process of knowledge exchange between professions

A case study of the process of hybridisation in a private health care organisation

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Abstract

Hybridisation as a means of accounting knowledge permeating the practices of organisations has been an important element of the reformation of the public sector over the recent decades. The study examines this issue in the context of a private health care organisation in the role as provider of public services. The management control framework of Alvesson and Kärreman (2004) in combination with hybridisation theory constitutes the theoretical framework. Through a qualitative study of three business areas of the Swedish private health care organisation 'HealthCo', the study concludes that: (i) the process of hybridisation is dependent on the interfaces between technocratic and socio-ideological controls, (ii) the process of hybridisation is to be interpreted as a knowledge exchange rather than as a knowledge transfer (iii), the process of hybridisation is dependent on factors such as "dual" transparency between professional groups, manner of implementation, complexity of care provided and the organisational structure, (iv) accounting develops and refines as a result of hybridisation and (v), the process of hybridisation is continuous and may be interfered or even ceased at any point in time.

Keywords: Hybridisation, Health care, Accounting, Sweden, Private health care organisation
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1. Introduction

> Just how does accounting's emphasis on the economic relate to the interests and practices of those who seek to extend the visibility of the technical, the human and the wider environmental characterisation of organisational performance? And how does accounting's commitment to the detached, analytical consideration of the new relate to the need to generate the commitment which may play a determining role in the realisation of the actual?
> (Hopwood, 1983, p. 291)

Accounting serving as a base for processes and actions is vital for the functioning of every organisation (Hopwood, 1983). This has however not always been the case. Over times, throughout the social, organisational, legal and economic environment in which accounting operates, it has transformed from the role of bookkeeping to a strategic source of intelligence and "a proactive means of both knowing and doing" (Hopwood, 1992, p.126). Accounting has emerged through professions such as economics and marketing, and so has also accounting influenced other professions. When skills and competencies from one profession are transferred to another profession, this is referred to as *hybridisation*. It is the process of hybridisation, through the exchange of knowledge between professions and the consequences of adopting accounting knowledge that will be the focus of this thesis.

As part of the reformation of the public sector over the recent decades, accounting techniques and processes has been introduced to the very core of the public sector organisations as a means of achieving increased control and efficiency. This development, which is observed in almost every European country, is referred to as *New Public Management* (Hood, 1991; Quaye, 2001). The main element in these reforms was the introduction of market forces and thus internal competition to the public sector (Charpentier and Samuelson, 1996). The health care organisation has become a special case in this development due to its institutionalised characteristics and the strong professional autonomy among health care professionals (Meyer and Scott, 1992). Several studies reveals that hybridisation as a means of introducing accounting to the health care profession has been discouraged by health care professionals, as increased control and transparency have been understood as a threat to their medical autonomy and the ethical norms of the medical profession (see e.g. Jones and Dewing, 1997; Kurunmäki et al., 2003; Lapsley, 1994; Pettersen, 1999). However, some studies provide evidence of hybridisation among health care professionals and that accounting actually permeates the technical core of the organisation (Kurunmäki et al., 2003; Kurunmäki, 2004). Due to its organisational complexity, the health care organisation makes up an interesting empirical arena for studying the process of hybridisation. A rather new type of health care organisation that has developed as a consequence of the reformation of the public sector is the *Private health care organisation* operating according to a purchaser-provider model. In Sweden, which makes up the national context for this study, the reformations started in 1992, with the introduction of the Stockholm Model. The private health care sector in Sweden will make up the empirical arena for the present study. The lack of empirical research of the hybridisation process in this type of organisation calls for more research on the hybridisation process in this empirical context.

Previous research on hybridisation takes a rather static perspective, investigating whether or not hybridisation takes place. However, the fact that organisations constantly change, would

call for a more dynamic approach to hybridisation, with the standpoint of an on-going process. In addition, the fact that hybridisation involves accounting techniques being transferred to another profession, opens up for questions regarding how accounting transforms and how knowledge between professions are exchanged throughout this process.

In this study, interviews were conducted within three different business areas in a private health care provider (HealthCo). This method allowed for highlighting possible differences in the hybridisation process between areas providing different types of care. The empirical data from these interviews was analysed in relation to previous findings of the use and adoption of accounting techniques in primarily the public health care sector. The management control framework of Alvesson and Kärreman (2004) was used to explain the differences observed using the concept of *technocratic* and *socio-ideological control.* Through this approach, the aim of the present study is to increase the understanding of how accounting techniques permeate the practices of health care professionals.

The research question of the present thesis is:

> *What characterises the hybridisation process in a private health care organisation?*

The research question was operationalised by conducting an in-depth qualitative case study of a Swedish privately owned health care organisation, hereafter referred to as 'HealthCo'. Within the frames of the case study, a total of 36 interviews were performed. A pre-study with four open-ended interviews initiated the research. Thereafter, 32 semi-structured interviews were conducted with administrative[1] and health care professionals on all management levels within three different business areas of HealthCo.

1.1 Outline

The thesis is structured as follows. The introduction chapter ends with a background section giving a review of the recent reformation of the European public sector in order to present the empirical context of the case company, HealthCo.

In the next section (2. Theory), the theoretical framework, which will serve as the base for the study, is described and positioned in relation to previous research of the hybridisation process. As a tool for analysing the empirical data, Alvesson and Kärreman's (2004) framework for management control will be presented. This theory review results in a theoretical model, which will be contrasted with the empirical data in the analysis (5. Analysis) and the following discussion (6. Discussion). The main conclusion when theorising relevant previous research is that a more dynamic approach to hybridisation would facilitate a better understanding for the role of hybridisation in the development of accounting.

The third section (3. Method) will present the method for the study and how the empirical data was collected an analysed. In summary, the study was conducted based on 36 interviews of which 32 were semi-structured and performed within three business areas of the private health care organisation HealthCo. The other four interviews were open-ended pre-study interviews. In the fourth section (4. Empirics), the empirical data of the study is presented.

[1] Hereafter the terms *health care professionals* and *administrative professionals* will be used as a broad categorisation of the different roles in the health care organisation. Health care professionals are defined as having a main educational background within medicine, and administrative professionals as having a main educational background outside medicine, such as economy or social sciences.

First, a brief description of the case organisation HealthCo is given. This will be followed by empirical data for each business area; Primary Care, Geriatric and Artro. Each business area description will end with a summary of the management controls identified in each area.

In the fifth section (5. Analysis), the management controls identified in the empirical data is analysed in relation to the control framework of Alvesson and Kärreman (2004) and in relation to previous studies of hybridisation in health care organisations. The findings from this analysis are discussed in the sixth section (6. Discussion) and conceptualised into a model of the process of hybridisation in HealthCo. In the final section (7. Conclusion), the study and its key findings are summarised and discussed. This section also opens up for a discussion on future research questions and the limitations with the present study.

1.2 Background

In order to develop the understanding of the hybridisation process in a private health care organisation, this section will give the reader a review of the environment from which hybridisation stem from. This review will take its starting point from the reformation of the European and the Swedish public sectors over the recent decades.

1.2.1 Reforming the public sector

During the 1980's and the 1990's, the concept of New Public Management (NPM), first referred to by Hood (1991), came to characterise the development of the public sector in almost every European country (Charpentier and Samuelson, 1996). One general trend in this reformation was the introduction of market forces, with the intention to accomplish a better use of recourses in a sector that was considered too large and inefficient (Blomgren, 2003). The reform was subsequently not intended to change the services of the public sector, but rather the way in which these organisations were managed (Brunsson and Sahlin-Andersson, 2000). New management control systems emphasised aspects such as cost control, greater accountability, and financial transparency (Quaye, 2001). In the UK, one of the main changes was the separation of the purchaser and the provider in the NHS (National Health Service). As a result of this change, the consumer's own ability to choose provider was enhanced. This development also came to characterise the NPM reform in Sweden (Charpentier and Samuelson, 1996). The reform caused independent, but publicly owned organisations, to become competitors on an internal market. In addition, private providers were established and started to compete with publicly owned actors (Saltman, 2003).

1.2.2 NPM in the Swedish health care sector

The health care services in Sweden have traditionally been operated by the County Councils[2], which are the authorities responsible for health care in different geographical areas. In the County Council of Stockholm, the reform began in 1992 with the introduction of the so-called Stockholm Model (Quaye, 2001). The model rests upon three main pillars. The first was the implementation of a purchaser-provider model, separating the purchasers (the politicians) and the providers (hospitals and other health care service providers) of health care. The County Council became the purchaser who made health care agreements regarding price, volume and services. For patient services, a price list was developed around so called DRG-points based on diagnostic related groups. The DRG-system classifies hospital patients according to their case mix (as measured by diagnoses and patient characteristics) and according to homogeneous treatment costs (Schmid et al., 2010). In this way, DRG's define the health care provider's products and serve as a basis for financing schemes, health care management, planning, and utilisation reviews (Rodrigues, 1993).

[2] When translated to Swedish, County Council is the same as Landsting.

The second pillar was the introduction of a system in which the patients could choose their health care provider, which consequently resulted in competition between the providers. The third pillar was the development of public health care units as freestanding profit centres. In addition, in order to reduce the waiting-time for receiving treatment, a health care guarantee program was introduced which guaranteed treatments within three months (Blomgren, 2003). In accordance with developments in other European countries, the NPM reforms in Sweden also opened up for private health care actors to establish themselves as providers of public health care (Saltman, 2003).

1.2.3 The public debate

Over time, an increased patient awareness has resulted in a public debate in Sweden concerning profits made by private health care providers on public tax spending (Blomgren and Sundén, 2008). The fact that several of the large private health care providers are owned by private equity funds, and in addition actively avoid paying taxes tax in Sweden, has created a fierce and many times animated debate, many times with a political and ideological background. In addition, the quality of private health care has been seriously discussed since it has come to light that some of the private actors do not meet acceptable quality standards, which has created a public perception that profit goes before service. These types of scandals have created negative perceptions in the public opinion regarding private health care providers in Sweden (Helgesson and Winberg, 2008; Svenska Dagbladet, 2011).

2. Theory

As described in the introduction section, there is an increased financial pressure on the public sector, which has resulted in an increased use of accounting techniques in the recent decades, with the intention to achieve better financial control (see e.g. Hood, 1991; Rose and Miller, 2010). This has not been without problems. Several studies have found that the health care profession, which has a tradition of autonomy, has difficulties to accept an increased use of management controls (see e.g. Jones and Dewing, 1997; Kurunmäki et al., 2003; Lapsley, 1994; Pettersen, 1999). The problem has two dimensions. One dimension concerns what context that foster one profession to acquire knowledge and expertise from another profession. The second dimension concerns the control systems and how they are applied in the organisational setting. In order to fully illustrate the complexity of the problem, attention will be given to the process of hybridisation in relation to the interfaces of different organisational controls. First, attention will be given to hybridisation theory and the outcome of previous literature. Thereafter, a review of the relevant literature concerning management control and the interfaces of different forms of management controls will be given. Finally, these theories will be analysed in relation to each other.

2.1 Hybridisation, a mix of two professions

Kurunmäki (2004) refers to the adoption and use of management accounting techniques among medical professionals as *hybridisation*. One example of this phenomenon is when health care professionals prepare budgets and design control systems with financial and non-financial output measures. There is evidence that organisations that initially has been reluctant to increased use of control, in some cases have found the new organisational accounting language to displace the dominant culture such as the traditionally dominant culture recognised in health care organisations (Power et al., 2003).

> … there is evidence to suggest that in the area of health care the sacred domain of clinical action is becoming influenced, although not yet comprehensively transformed, by accounting initiatives […] as the accounting language of budgeting attempts to occupy clinical discourse it has the potential to control significant definitions of the hospital environment.
> (Power et al., 2003, p. 145)

A theory closely related to hybridisation is *accountingisation* and *polarisation*. Regardless of the different labels, these theories all refer to the permeation of accounting techniques in the health care practices (Kraus, 2012). These theories have both been widely studied in public health care organisations, particularly in relation to the NPM reforms (see e.g. Jacobs, 2005; Kurunmäki et al., 2003; Kurunmäki, 2004). As they appear as very similar in terms of their organisational implications, they are all relevant for the present study. Therefore, for simplicity, these theories will be referred to as *hybridisation*.

While several studies have found management accounting techniques being borrowed by other professions (Hopwood, 1992; Miller, 1998), Kurunmäki (2004) argues that in some contexts, the techniques can even be seen as “readily transferrable” to other professions (Kurunmäki, 2004, p.342). She concludes that the hybridisation in her study of the health care reforms in Finland is achieved through the clinicians absorbing the management accounting practices of free will rather than management enforcing this process. In order to understand

why and when hybridisation takes place, it is crucial to understand why resistance to this type of development arise. Health care organisations are unique in the sense that they are generally institutionalised and professionally structured with a very strongly ordered hierarchy. Such organisations protect their formal structures from evaluation since attempts to increase efficiency may undermine the so-called ceremonial conformity of the organisation and in turn impair the organisation's support and legitimacy (Meyer and Scott, 1992).

> Technical activities and demands for efficiency create conflicts and inconsistencies in an institutionalised organisation's efforts to conform the ceremonial rules of production… These inconsistencies make a concern for efficiency and tight coordination and control problematic.
> (Meyer and Scott, 1992, p. 37)

This suggests that an increased use of accounting techniques in health care organisations would challenge the ceremonial conformity of the organisation and potentially results in inconsistencies and resistance. In Blomgren's (2003) study of the Swedish health care reform, the resistance to change is explained by the conflicting ideals that the reforms bring about. The nurses found that the reform results in a lack of balance between two different ideas of identity that characterises the profession; the idea of the nurse as an administrative leader and the idea of the nurse as an expert in caring. In order to defend the latter, who the nurses perceive as suffering under the changes of the reform, they initiated a quality assurance program. The ability of the accounting techniques being transferred to and absorbed by the medical profession is referred to as *mobility* (Kurunmäki, 2004). Apart from the ideologies of the health care professionals, several other factors are found to influence the mobility. One is the use of a formal system to measure performance (Kurunmäki and Miller, 2006), and another is an organisational structure that provides incentives to absorb accounting techniques (Jacobs, 2005). Kurunmäki (2003) suggests that the most important factor is an external pressure for increased use of accounting techniques and information. A second factor is the manner of implementation, meaning that a stepwise and slow implementation rather than a hectic implementation will facilitate hybridisation. Finally, the absence or presence of institutional barriers and constraints may play an important role. It is argued that the absence of a well-established accounting profession in Finland made the health care professionals more receptive to accounting ideas. It is suggested that this environment gives the health care professionals space to learn about accounting techniques and practices and to take own initiatives in designing their own information systems. Jacobs (2005), supports this observation and argues that due to an already established accounting profession in the UK, health care professionals deemed that being engaged with accounting information was the "accountants job".

The table below provides a summary of some of these factors which are found affecting the hybridisation process.

Table 1. Literature review - Factors affecting the hybridisation process

Author	Type of study	Factors
Abernethy and Stoelwinder (1995)	A study of a University Hospital in Australia	Socialisation and training Meaning that this would facilitate an acceptance of bureaucratic forms of control.
Blomgren (2003)	A study of the nursing profession in connection to the NPM reforms in Sweden	Professional consequences of increased use of accounting Effects on the profession's identity, knowledge system and core activities, meaning that increased financial responsibility was expected to strengthen the professional position of nurses in relation to physicians and they felt that their position had been acknowledged.
Jacobs (2005)	Comparative study of health care organisations in Germany Italy and UK	Organisational structure motivating health care professionals to engage in accounting Accounting knowledge was required for certain attractive positions in the health care organisations in Italy and Germany. Managerial positions that include both managerial and clinical responsibility It was found that health care professionals were more willing to take on a management role (including financial responsibility) if it involved clinical responsibility.
Kurunmäki et al. (2003)	Comparative study of intensive care units in Finland and in the UK	Pressure from external environment Manner of implementation of accounting Meaning that a slow and step-wise implementation rather than a hectic implementation facilitates the hybridisation process. Absence of professional or institutional constraints Meaning that the absence of a well established accounting profession facilitated the hybridisation process.
Kurunmäki (2004)	Study of the Finish NPM reforms	A particular configuration or assemblage of accounting techniques Institutional location Meaning that the role of accounting in Finland as a broader discipline of business and Economics facilitates hybridisation. Pedagogic mechanism Professional associations Accounting in Finland is suggested to be seen as a craft rather than a profession as it is seen in the UK.
Kurunmäki and Miller (2006)	UK study the effects of a government programme	The development of formalised performance measurement systems Hybridisation may be discouraged if accounting gives: - more attention to financial rather than social factors - only a selective view of the organisation's outcome
Llewellyn (1998)	Study of social services in Scotland	Breaking down the boundaries between costing and caring in social services through showing how these are similar and how costing may support rather than threaten caring. This was accomplished through: - Creation of care managers with budget responsibility - Decentralisation of accountability for budget - Financial squeeze on public sector as a whole - New people came to occupy key positions in the organisations meaning that new people broke down the cohesiveness of professional groups.

Reflecting upon previous literature concerning hybridisation in health care, it is evident that this subject has been thoroughly studied. However, to date, research has primarily focused on the hybridisation process in the context of the public health care organisation. The private health care organisation operating as a provider of public health care makes an interesting empirical arena due to the meeting between the different objectives of these two organisations. Further, in previous literature hybridisation is described from a more *static* perspective, in which health care professionals either are seen as hybridised or not. This allows for studying hybridisation from a *process* perspective, in which hybridisation can be seen as a continuous process that can be interrupted or ceased at any point. Previous literature on hybridisation has primarily focused on how health care professionals adapt to accounting techniques. This allows for studying what roles other professions, such as the administrative profession, can take on in the process of hybridisation and what consequences this can have for the development of accounting.

2.1.1 Limitations

The institutional and professional factors in the above summary table will not be taken into consideration in the present study. Country specific factors, the role of professions and the manner of implementation of reforms will subsequently not be studied. However, some of these factors such as manner of implementation are relevant from an organisational standpoint meaning implementation of accounting techniques in an organisational context. Subsequently will some of these factors be relevant in an organisational rather than an institutional or a country specific setting.

2.1.2 Decoupling: a two-parted organisation

Health care organisations such as hospitals are generally seen as loosely coupled (Orton and Weick, 1990), meaning that the organisation *decouples* the administrative part of the organisation (the formal structures) from the medical activities. By dividing the organisation into two different organisational structures; the organisation manages to formally change in a way that satisfies requirements from the environment (for example increased control) and simultaneously informally preserves the medical structure (Meyer and Scott, 1992). Harris (1977) describes the relationship between the medical staff and the administration as locked in a non-cooperative oligopoly-type game. Covaleski and Dirsmith (1983) suggests that the medical core of the organisation, working back stage, should be represented by a nurse administrator using a bureaucratic mask for communication with the administrative structure while using a clan mask for communication with the medical core. In a discussion about institutional rules in the mental health system, Scott and Meyer (1994) highlight the advantages of decoupling.

> One can see the decupling system easily in the practical literature it generates … Rational organisers commonly see such a system as arising from sloth, inefficiency and a lack of intelligent thought and management. They are wrong: the obfuscation is necessary and reasonable, created by people trying to protect some order in a conflicting and inconsistent environment … It takes very able and thoughtful people to write and formalise descriptions of a mental health organisation and treatments cannot be understood.
> (Scott and Meyer, 1994, p.225)

The use of accounting techniques in a health care organisation in order to increase efficiency and control may therefore necessarily not function as intended. Accounting, as part of the administrative structure, may rather function as a way for the organisation to legitimise their medical activities (Pettersen, 1999). This observation is confirmed by Kurunmäki et al. (2003)

in a comparative study of intensive care units in Finland and in the UK. In UK, the organisation was found to be decoupled and the accounting was used as a legitimating tool with the purpose of defending the activities of the health care professionals. In the Finish case, the organisation was found decoupled, but accounting was used as intended, as a tool for management control, rather than as a tool for legitimation. Health care professionals in Finland assumed the role of the accountant and so-called "clinician-management accountants" was developed in conformity with the concept of hybridisation described above. In this study it is suggested that decoupling may be affected by the characteristics of the type of work that is performed by the organisation. It is argued that the interdependence of team members, for example within an intensive care unit may reinforce decoupling.

2.1.3 Hybridisation in a private health care organisation

As described in the background information about private health care in Sweden, HealthCo is closely tied to the public sector as a provider of public health care, although privately owned. This motivates the use of previous literature on the hybridisation process in public health care organisations in the present study. Given previous literature emphasising the importance of external pressure, it is for example likely that the external pressure on a private health care organisation is larger than on a public health care organisation. A private health care organisation can be seen as under a dual external pressure; both from the government/society (expecting quality and efficiency in the services they purchase) and from the owner's of the company (expecting return on invested capital). In addition, it is likely that the latter of these pressures generates resistance from the health care professionals in the private health care organisation if the organisation does not succeed in breaking down the barriers between costing and caring as described by Llewellyn (1998). It is likely that health care professionals see this type of external pressure, with increased control, as a threat to their medical autonomy and as opposing their professional values of "caring".

2.2 Controlling Health Care

Management control is an extensive research field and over the previous years, research has presented various approaches to this area. Naturally, there is no universally accepted definition of "control" as it applies as a function of management (Merchant and Van der Stede, 2007). However, a general view is that management control refers to actions taken by managers to ensure that subordinates act in accordance with organisational objectives and goals (Merchant and Otley, 2006). Management control systems (MCS) refer to systems of different levels of controls (Malmi and Brown, 2008). Some studies have focused on a specific area of the management process. For example, Merchant and Van der Stede (2007) specifically focused on how strategies were implemented through influencing employee behaviour. Others have applied a broader perspective by also including the process of setting organisational objectives in the MCS (Merchant and Otley, 2006). A comprehensive review of management control is, however, outside the scope of this thesis.

In order to determine which of the management control models to use in the analysis of empirical data, it is important to discuss the organisational context in which they will be used. Focusing on health care organisations, there are several factors preventing managers from effective use of management control (see e.g. Kurunmäki et al., 2003; Llewellyn, 1998). The problem has two dimensions. One is that administrative managers try to influence the behaviour of health care professionals, using accounting tools and techniques such as output control and behavioural control (Alvesson and Kärreman, 2004). An increased use of these types of controls has been observed in the public sector due to the emergence of new public management in the recent decades (Hood, 1991). The other dimension is of a social character and concerns how accounting influences meanings and actions within the organisation

(Hopwood, 1983). Health care organisations are characterised by professionals having their own traditions and culture, informal hierarchies and ideologies (Abernethy and Stoelwinder, 1995). While the managers in the present study operate in a company which existence is dependent on making a profit to its owners, the health care professionals from the point of view of their profession, operates in line with the quality standards and ethics corresponding to those of a public sector health care organisation. The loyalty of the health care professionals is generally bound to their profession rather than to a specific organisation (Anthony and Govindarajan, 2007). Therefore, the health care organisation can be viewed as a general example of an organisation using professional or clan control (Ouchi, 1979). This reliance of social forms of control is as well in line with the evidence that health care professionals historically have given little attention to cost control (Anthony and Govindarajan, 2007). As the work of the health care professionals is dependent on human beings, not everything is predictable and not everything can be planned for. In a critical care situation, it is for example unlikely that the health care professional takes cost into consideration over saving lives.

Despite the complex view of the health care organisation pictured in previous research, there is evidence that accounting techniques actually can be included in the practices of health care professionals (Kurunmäki et al., 2003; Kurunmäki, 2004; Llewellyn, 1998). This suggests that there may exist a link between manager's use of output control and the professional ethics of the health care professionals. This calls for a control model that captures the relationships between different forms of controls. Alvesson and Kärreman (2004) have developed a management control model that pays close attention to the interfaces of control. In addition, their model includes both formal and informal forms of management controls. This broad approach appears favourable in studies of health care organisations due to the many informal controls and hierarchies present in this type of organisation (Hopwood, 1974). Alvesson and Kärreman (2004) argue that management control can be divided into *technocratic* and *socio-ideological*. Technocratic controls represent direct control of workers behaviour such as budgets and standard procedures. Socio ideological controls represent managers efforts to control the worker's mind-set, to "persuade people to adapt to certain values norms and ideas about what is good, important, praiseworthy etc. in terms of work and organisational life" (Alvesson and Kärreman 2004, p.426). Rather than assuming these two types of control in pure forms, they argue that there is a close relation between them and that these forms have a significant effect on each other. The Alvesson and Kärreman (2004) framework will be used as a tool to explain the hybridisation process in the present study as this framework will open up for analysis of the interfaces of controls that appears to play an important role in the health care organisation. It is first when accounting is analysed from an organisational perspective and in relation to other types of management controls, that the development of accounting processes can be understood (Hopwood, 1983).

> …rather than detaching accounting from its organisational setting, organisational researchers aim to understand the meanings which are given to accounting in particular settings, emphasising not the interpretation of an accounting given but the more active ways in which a particular account can shape, mould and even play a role in constructing the setting of which it forms a part.
> (Hopwood, 1983, p. 288).

However, in order to correctly apply the framework of Alvesson and Kärreman (2004) in the organisational context of the present study, the control categories within the framework of

technocratic and socio-ideological controls relevant for this study will be defined below. This will be followed by a discussion of its implications for the hybridisation theory.

2.2.1 Technocratic Control in Health Care

Alvesson and Kärreman (2004) define technocratic control as ”plans, arrangements and systems focusing behaviour and/or measurable outputs” (Alvesson and Kärreman, 2004, p. 425). The behavioural focus of technocratic control refers to rules, manuals, procedures, physical constraints, and processes that managers use to influence employees towards a desired behaviour. This represents the most direct form of controlling the behaviour of employees. By monitoring the behaviour of the workforce, managers can both detect and prevent undesirable behaviour (Merchant and Van der Stede, 2007). Output control in contrast, is less direct in the sense that it refers to controlling of output rather than the specific actions. Output controls build on financial and non-financial key performance indicators such as profit, customer satisfaction or other quality measures. Output control involves the whole process from defining a desirable outcome (e.g. setting a budget), to measuring outcome and may also include rewarding staff for achieving desired outcome.

As the health care organisations involve human beings, quality is of great importance. This has resulted in a large number of behavioural controls regulating health care practices. In addition, the nature of the health care activities makes output hard to measure. Task performance is inherently ambiguous and teamwork is common whereby it is in particular hard to measure the individual contribution (Ouchi, 1979).

2.2.2 Socio-Ideological Control in Health Care

Apart from output and behaviour control, there are other forms of control that managers utilise to guide the workforce. Socio-ideological control involves manager’s efforts to influence values and ideologies within the workforce. This involves attempts to control people’s mind-sets when it comes to social relations, identity formation and ideology. One direct form of socio-ideological control is recruitment and training. Through the process of hiring people with specific qualities or ideologies or give employees a certain development in terms of training, managers can create a more homogenous workforce (Alvesson and Kärreman, 2004).

Alvesson and Kärreman’s (2004) framework of control suggests that socio ideological control only refer to the control executed by managers. In the present study, socio-ideological control will be defined in a broader setting, also including the ideologies and social norms of subordinates. This is motivated by previous research arguing that informal groups, ideas and norms rather than a formal technocratic control system has a significant impact on the health care operations (Abernethy and Stoelwinder, 1995). Hopwood (1974) argues that in order for rules to be followed, they have to be accompanied by social control mechanisms which facilitates rules being “reinforced, accepted and reacted upon” by the subordinate (Hopwood, 1974, p.21). Hopwood (1974) argues that this social dimension of control supporting administrative forms of control can be divided into *social control* and *self control.* Both of these dimensions will be taken into consideration in the present thesis. Social control concerns the social relationships within the organisation and the motivations, expectations and social relations of its members. It emphasises that social control can be exercised both by subordinates and by managers, at all levels in the organisation. Self control concerns the needs, desires and integrity of the individual member of the organisation.

Through the use of the definitions of socio-ideological control, the aim is to identify and compare the ideologies and social norms within both managerial and subordinated groups of the case organisation.

In the below table, a summary of the Technocratic and Socio-ideological controls are given.

Table 2. Technocratic and Socio-Ideological Controls

Technocratic Controls	Socio-Ideological Controls
Rules	Self Control
Manuals	Social Control
Physical Constraints	Recruitment
Standards	Training
Processes	Meetings
Procedures	Ideologies
Plans	Socialisation
Budgets	Norms
Financial results	
Source: Alvesson and Kärreman (2004), Hopwood (1974), and Merchant and Van der Stede (2007)	

2.2.3 The interfaces of control in Health Care

An important element in the control model of Alvesson and Kärreman (2004) is how different forms of control are related to each other. They argue that different forms of control interact, merge and contradict each other and cannot be seen as separate and pure forms of control. In their case study, it is emphasised that technocratic control may be a potential source of hidden socio-ideological control. However, as a starting point in the present thesis, it is assumed that the opposite relation may also exist i.e. socio-ideological control being a source of technocratic control. In summary, the control model in the present study involves two forms of control; technocratic and socio-ideological control as illustrated in the below figure.

Figure 1. The Management Control framework of Alvesson and Kärreman (2004)

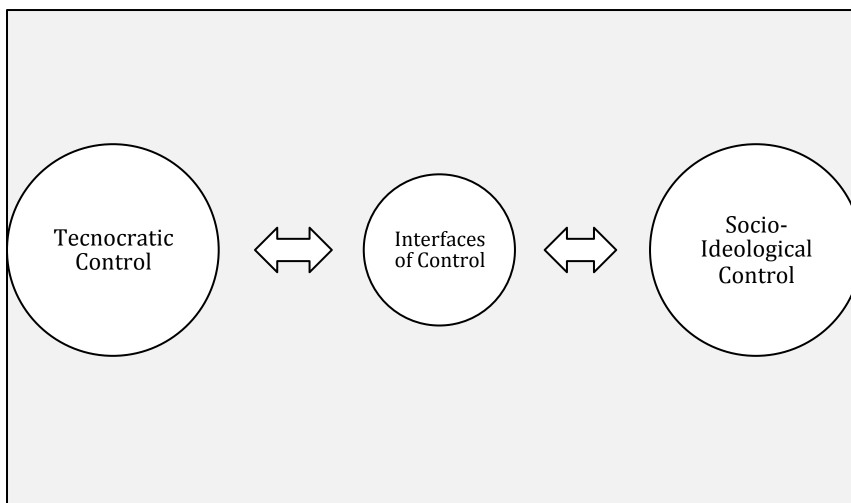


Illustration of the management control framework of Alvesson and Kärreman (2004) used in the present study.

2.3 Theorising the hybridisation process

To summarise, the issue of this study concerns the occasional reluctance among health care professionals to hybridisation. In order to understand how these processes work in a private health care organisation, it is reasonable to take the formal and informal control structure of

the organisation as a starting point. Previous research concludes that conflicting ideals in health care organisations is one source of problems in the hybridisation process (Blomgren, 2003). Given previous research, it is subsequently reasonable to assume that the control model of Alvesson and Kärreman (2004) will help to explain the role of accounting in the health care organisation. This opens up for several questions regarding the interplay between technocratic and socio-ideological controls in the process of hybridisation; how is the interaction of different forms of control affecting the hybridisation process? What combination and interaction of controls affect collaboration and information exchange between the administrative profession and the health care profession? How does the interplay of different forms of control differ between different health care units?

The present study aims at developing the understanding of the process of hybridisation within a private health care organisation. Previous studies on public health care organisations takes the health care professional as a starting point for investigating if and how they have absorbed accounting knowledge. However, is hybridisation really to be seen as a transfer of techniques from one profession to another or can there be another approach to this theory? May this process of hybridisation and the marrying of different ideologies also affect the administrative professionals? In addition, in case the process appears to affect the administrative professionals, can accounting itself also be affected? Kurunmäki et al. (2003) indicates that when accounting meets resistance it could transform from its original purpose. In their study, accounting takes the role of legitimating the operational activities instead of being used for control. On the basis of these findings, it is likely that accounting would possibly also be able to transform *within* its original purpose. What this refers to is the development and refining of accounting information and techniques to better reflect the nature of health care practices.

Drawing on observational data, it is demonstrated how the hybridisation can be seen as much more than a transfer of techniques. To start with, hybridisation can be seen as a continuous process of knowledge exchange between professions, in which also the administrative professionals takes an active role. This process is continuous in the sense that it may be interrupted or ceased at any point. Further, given this "mutual" hybridisation[3] of both health care and administrative professionals, accounting may be refined and developed in order to suit the health care professionals requirements. Kurunmäki (2004) touches upon this specific feature of the hybridisation stating that the transfer and accumulation of accounting techniques has a significant role in the development of management accounting. This statement is however not further discussed which opens up questions concerning what context that facilitates not only the hybridisation process as such, but also the development of accounting.

To summarise, the interface between the administrative professions' technocratic controls and the healthcare professions' socio-ideological controls creates the starting point for the process of hybridisation. The interface between the two professions and the exchange of knowledge that follows, contribute to a mutual understanding of the health care processes, which in turn is a prerequisite for accounting to develop in relation to the context in which it operates, or in the words of Hopwood (1983) "…accounting can be changed in the context of organisational and social conflicts and debates in order to create different but still persuasive images of

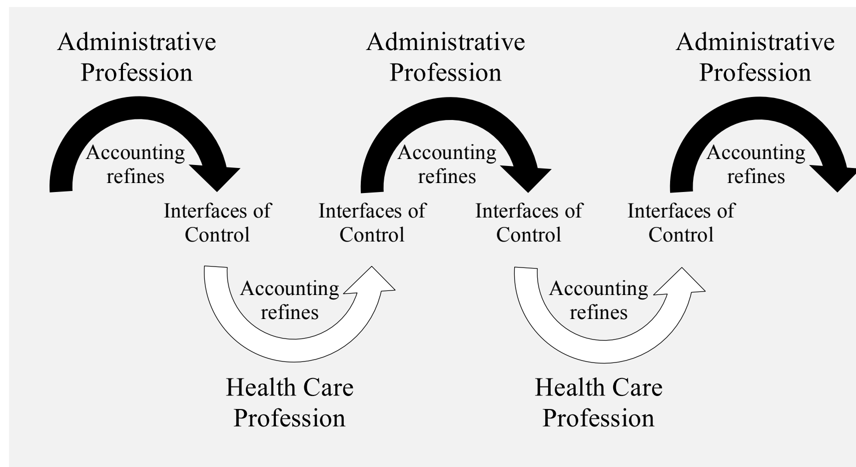
[3] However, it should be emphasised that the health care professionals hybridisation is more far-reaching than the "opposite" hybridisation of the administrative professionals. Even if they take on understanding of the medical operations, they do not learn the actual techniques of the health care professionals. On the other hand, the health care professionals learn the accounting techniques from the administrative professionals, and thus, becomes hybridised to a further extent.

organisational aims and achievements" (p. 290). The discussion can be summarised in Fig. 2, illustrating the process of hybridisation and the development of accounting in a health care context. This view of the process of hybridisation and the potential for a refinement of accounting opens up for several questions: how does this interface of control express itself in the health care organisation? What are the roles of the two professional groups? And how does the process of hybridisation become continuous, and can it develop accounting over time? Are there interruptions in this process and can it even cease? And may there be differences in the care processes that affect hybridisation, and thus, the refinement of accounting? This discussion with the following questions leads to a refined research question for the present study.

Refined research question:

> *How can interfaces of technocratic and socio-ideological control affect the process of hybridisation in different care units in a private health care organisation, and how can hybridisation be understood as a continuous process for refinement of accounting?*

Figure 2. The process of hybridisation



The model illustrates a theoretical view of how interfaces of control relate to the process of hybridisation.

3. Method

In this section the method that is applied in the study is presented and motivated in order to provide the reader with insight how the study have been constructed and carried out.

3.1 Why case study as research approach?

In the introduction it was described that there is a lack of empirical research regarding the hybridisation process in private health care organisations and how this process may affect the development of accounting. This was the starting point for conducting an empirical study of three different care units within a privately operated health care organisation. Studying management accounting in practice has been an approach that has received interest during the past years; an interest that "was initially promoted by a perceived gap between the theory and practice of management accounting…" (Scapens, 1990, p. 259). This gap between theory and practice motivated this study. From different sources it became apparent that health care operations were difficult to manage, especially due to the strong influence of different professions and hierarchies, the gap between what they had learnt about accounting at the university and the contrast with real life seemed large. Based on the perceived divergence between real life and the academic world, it was motivated to encounter this divergence by an empirical study of management accounting in practice.

When conducting empirical research in management accounting, different research methods may be used, such as field research, laboratory or field experiments, surveys or an analysis of archival records (Birnberg et al., 1990; Yin, 2009). Fieldwork could mean studies of social practices of a single company or a number of companies. When studying a single case, one usually refers to a case study; which might be a study of a whole company or a more aggregated unit of analysis (Scapens, 1990). A single case study may also be a combination of a single company in which several different units are studied, something that Yin (2009) refers to as an embedded single case study. Relating back to the purpose of this study, the case study model was chosen as research strategy, with the motivation that the authors aim for achieving a better understanding of how the process of hybridisation as a contemporary phenomenon may be investigated "in depth and within its real-life context" (Yin, 2009, p.18), in which the context comprises the private health care organisation. Case study as an empirical method is further supported by Scapens (1990) since it "offer(s) the possibility of understanding the nature of management accounting in practice: both in terms of the techniques, procedures, systems etc. which are used and the way in which they are used" (p. 264). When conducting case studies a word of caution is expressed by Scapens (1990) that the investigators "need to be careful to distinguish the formal accounting systems which senior managers believe are used and the ways in which they are actually used" (p. 264). This word of caution is taken into consideration when investigating the process of hybridisation, and is one of the explanations for why the framework of Alvesson and Kärreman (2004) is being used.

In accordance to the research question, which partly aims for investigating the development of accounting in connection to the process of hybridisation, the case study may be necessary in order to asses and evaluate management accounting and control systems in relation to their wider context (Otley and Berry, 1994). The need for studying the development of accounting in relation to the context in which it operates is also put forward by Hopwood (1983) who argues that "what is needed are more substantive investigations oriented towards providing

bases for understanding or explaining the workings of accounting in action" (p. 303). Even more recent studies have found that there is a need for more case studies in the field of accounting and management in order to capture the dynamic and contextual complexity of today's organisations (Irvine and Gaffikin, 2006).

When case studies are used in management accounting they may have a number of potential roles to play, in which the central role seems to be exploration. Exploration goes beyond the idea of only describing the actual case and focus more towards explaining the reasons for observed accounting practices (Otley and Berry, 1994; Scapens, 1990). Performing a case study can facilitate the generation and modification of theories, and they are particularly valuable in those cases in which existing theories are inadequate or only partly explain the phenomena of interest (Otley and Berry, 1994). The aim with the thesis is an attempt to build further on the current theories regarding the hybridisation process in the health care context, which has been referred to in the theory section above. In this sense the thesis takes on an exploratory approach by investigating the process of hybridisation in a private health care organisation.

Case studies may be conducted as single or multiple studies and there are both advantages and disadvantages with both methods. Relating back to the research question the single case study appeared appropriate for the current analysis due to several reasons. First of all, the authors were thinking of conducting a multiple case study in which the process of hybridisation was to be contrasted between two different health care organisations; one public health care organisation and one private health care organisation. However, this idea was rejected with the motivation that an in-depth investigation of one single unit would provide a more thorough empirical material for understanding the process of hybridisation and that the authors would be able to dig deep in one case. This reasoning is in line with that of Dubois and Gadde (2002) who argue "when the problem is directed towards analysis of a number of interdependent variables in complex structures, the natural choice would be to go deeper into one case instead of increasing the number of cases" (p. 558). There were also a limited time frame for the present study and the authors realised that it was enough to focus on one particular organisation. Scapens (1990) emphasises the importance for researcher to place some limits on the subject being studied. Second, in the current study, the authors were given free access to study every unit in the health care organisation, access to business intelligence systems, ability to participate in management meetings, in leadership courses and shadowing management in their daily work, access to observe the actual treatment of patients at the different facilities etc., with this complete access it was deemed better to take care of this opportunity to gather valuable empirical data. When conducting case studies, good access to organisations is an important necessity (Scapens, 1990), which was certainly the case in the present study. In that sense, the choice of case can partly be seen as a revelatory case, since the authors were given access to information that researchers not always are able to take part of (Yin, 2009).

In order to achieve some of the possible advantages of studying multiple cases, three different business areas in the single case were chosen, something that Yin (2009) refers to as an embedded case study. Including different units in the single case can add opportunities for a more extensive analysis, which in turn may enhance the insights in the single case. Through inclusion of different business areas with e.g. different complexities in care, the authors sought for being able to illustrate the research question from different angles. Since the thesis takes its standpoint from a single case, a comparative study of the different units within the organisation may also add to the existing literature on hybridisation, such as Kurunmäki et. al.

(2003) who study the same type of intensive care units, but at four different hospitals, in two different national contexts.

In several textbooks, articles and dissertations, the research process is often described as linear and in which the activities in the research process seems to succeed each other almost as if they were parts of the list of contents. The authors to this thesis have a different experience, which instead has been characterised by the movement back and forth between the different parts of the thesis. In other words, theory was added and removed simultaneously as the empirical data were collected and analysed, since it was hard to find theory before the authors really had understood what was going on in the health care organisation being studied. Afterwards, the authors have found out that this process of moving back and forth between theory and the empirical data is named *systematic combining* (Dubois and Gadde, 2002). Dubois and Gadde (2002) argue that “a standardised conceptualisation of the research process as consisting of a number of planned subsequent ‘phases’ does not reflect the potential uses and advantages of case research” (p. 555). The authors found that systematic combining was a more fair description of the real research work, in contrast to the more common description of research as linear and neat.

3.2 Why a private health care organisation?

A private health care organisation was chosen as a case for this thesis since both the ownership and the health care organisation as such provides an interesting setting for studying the process of hybridisation. The case organisation is HealthCo, which is a European private health care organisation headquartered in Sweden and owned by private equity funds. The different business areas of HealthCo are spread across the country, with sometimes several business areas present in the same region. The diversified business areas of HealthCo provide a suitable base for studying the process of hybridisation in relation to different types of care operations.

The health care organisation is an interesting arena for studying hybridisation processes since it is characterised by both strong internal hierarchies in the medical profession, especially between the physicians and the rest of the health care professionals, but also since the New Public Management and the introduction of market forces in the medical system has created tensions between different professions, such as the administrative professionals and the health care professionals. The private ownership, adds an extra flavour to the case, especially since the public debate tends to question if private ownership with objectives to generate profit at the taxpayers expense is compatible with good health care. Therefore, the study area Geriatric was included since this is an area in which private health care has been questioned. As described in previous research, the authors found relatively few studies that had been conducted in a private setting, which made it even more interesting to look into this organisational form.

3.2.1 Selection of health care business areas: Primary Care, Geriatric and Artro

As part of the embedded case structure, three different business areas within the HealthCo were selected. When selecting the cases the authors were totally free to decide upon which parts of the organisation that were to be included. The authors main point of contact in HealthCo, the CEO of HealthCo, emphasised the importance of not only studying the success stories of HealthCo and emphasised further that the authors should include “some areas that are managerially complex and that don’t really function as we would like them to” (CEO HealthCo).

When choosing business areas the authors strived for studying as different areas as possible in regards to the following criteria: (i) complexity of care operations (defined as aggregated level of education among staff), (ii) reimbursement model, (iii) turnover, (iv) number of employees, (v) educational background of employees, (vi) case mix of patients, and (vii) teamwork versus solitary work. Since the authors sought to study three business areas that were as different as possible with regards to the criteria mentioned above, Stockholm and thus Sweden was chosen as County Council and country for the study. The reasoning behind this was that the Stockholm County is the geographical area with the most diverging levels with regards to the above criteria. Further, there are large differences between the different County Councils in Sweden, and the authors preferred to study three different business areas operating in the same County Council. The reasoning behind this was that it would be easier to contrast the potential differences in the hybridisation process between the business areas if the political context were the same for all of them, since the County Council has a large influence on health care services due to the purchaser-provider model and the County Councils maturity when it comes to allowing private companies to manage the health care operations.

Together with the CEO the authors agreed on studying the following three business areas: Primary Care, Geriatric and Artro. Primary Care is the largest business area with the least complex operations; the Geriatric the second largest business area with medium complex operations; and Artro being the smallest business are with the most complex care operations. The interviews have been conducted in person by visiting the sites of the health care operations, and in those cases that personal interviews have not been possible, they have been conducted through the use of HealthCo's internal videoconference system. These interviews have been as close to real life interviews as possible without having physical meetings (see Appendix 1).

3.3 How was the empirical data collected?

3.3.1 Semi-structured interviews as primary source

The primarily source of empirical data for this study has been personal interviews performed by both authors. Collecting evidence from interviews is most usually associated with case studies and provides a good base for the research (Ryan et al., 2002). Interviews are also an essential source for researchers to gain access to participants understanding of action and events (Darke et al., 1998). A total of 36 interviews with 31 different persons have been conducted for the thesis. The interviews lasted between 30 minutes and two hours and 15 minutes, with an average duration of about one hour and 15 minutes (see Appendix 1). When choosing interviewees the authors aimed for interviewing both health care professionals and administrative professionals at all management levels in each business area. In addition, several physicians, nurses, assisting nurses, physiotherapists, controllers etc. were interviewed in the actual operations. The authors were free to select any person in the organisation for interview. However, this process was conducted in discussion with managers in each business area in order for the authors to have some guidance on the process. The discussion started with the CEO who connected the authors to the three business area managers. Thereafter the business area managers assisted in establishing contact the responsible managers in each part of the business areas being studied. In with several managers on a business level, the targets were chosen based on the criteria used for the business areas above, in order to interview managers and other staff with such large diversity as possible.

3.3.2 Pre-study Jan 2013 – Mar 2013

The process of collecting empirical data was initiated by a pre-study with four open-ended interviews. The aim of this study was to develop the understanding of both the health care and administrative professions in relation to each other, and also to improve the authors' basic understanding of HealthCo and health care operations in Sweden. During the pre-study the following were interviewed: the CEO of HealthCo, one business area manager in HealthCo, a physician working as managing director for a leading management consultancy firm and responsible for their health care division (external to HealthCo), and a physician (external to HealthCo).

3.3.3 Main study Mar 2013 – May 2013

In the main study the authors interviewed 32 administrative professionals and health care professionals on all management levels in the three business areas; from the CEO of HealthCo, down to the health care and administrative personnel working in the operations of each business area. Both authors have conducted all these interviews personally. Interviews on all management levels were viewed as important in order to receive as many different perspectives in relation to the overall aim of the thesis. The interviews in the main study were semi-structured, and the questions were partly formulated based on the pre-study and also on previous interviews. Semi-structured interviews are a common method used in accounting for collecting empirical data (Lee and Humphrey, 2006). In this case the interviews followed the research question but were more of an open discussion. The templates that had been constructed for the interviews were used as guidance for the discussion and were not followed as strict checklists, which is to prefer when conducting case studies (Rubin and Rubin, 1995). The interviewees were promised anonymity and the company name was changed to a pseudonym. This was done in order to be able to use the titles of the interviewees in the empirical data without confessing their identity.

Since the aim of the interviews was to explore the interface between technocratic and socio-ideological controls, and due to the more 'soft' nature of especially the socio-ideological controls, the authors were obliged to ask questions in which those interviewed were encouraged to fully explain underlying meanings and feelings. In order to try to fully understand these underlying interdependences, which in some parts were sensitive for the interviewed, there was a large need of building trust between the authors and those interviewed. This is probably one of the explanations for why the interviews on average had a duration over one hour. This need for building trust with the targets of interview was the main explanation for why the authors preferred to interview in person, and also in order to be able to observe facial expressions and body language. In those cases were a physical meeting was not possible (four interviews of 36 in total) HealthCo's internal videoconference system was used. Direct observation and participation in management meetings, coffee-rooms, leadership courses etc. were possible in connection to the interviews with several of the employees. This made it possible for the authors, at least to some extent, to confirm the examples given in the interviews of practical situations and their behaviour in relation to how they acted in the everyday life. There is a risk with interviews that those approached may try to have their behaviour to look better than is actually the case (Darke et al., 1998), why the authors tried to shadow the employees to such a large extent as possible. All interviews were recorded with a tape recorder after the interviewee had given consent. During the interviews the authors took notes regarding such information that could not be recorded, e.g. when illustrations were drawn or documents discussed. The interviews were transcribed in direct connection to the interviews, by one of the authors while the other read through the transcription and added own reflections or notes.

3.3.4 Additional data sources: direct observation, documents and a leadership course

When conducting case studies, interviews may be an important empirical source, however, it is argued that it may be necessary use multiple sources of evidence in order to improve the quality of the study, such as artefacts, questionnaires, observation of actions and meetings, assessing the outcomes of actions, and documents (Ryan et al., 2002; Scapens, 1990). Therefore, the authors have complemented the interviews with empirical data from other sources.

In connection to the interviews the authors had the advantage of visiting different sites within HealthCo, and mainly within the three different business areas. The authors were taken on guided tours in the premises where different medical equipment, surgical procedures and financial reporting systems were demonstrated. During the visits, the authors had the privilege to meet employees and patients and were given time to ask them questions about the health care operations and their treatment at the business areas. In addition, the authors participated in clinical meetings, had lunch with the staff in coffee rooms and drank several cups of coffee and tea together with employees at all hierarchical levels. The authors' thorough attempt to understand the 'clinical environment' was deemed as necessary, both in order to identify the socio-ideological controls that could be hard to grasp at a first glance, and to develop the trust needed for the interviews in order for the interviewees to feel comfortable and able to be honest with the authors. Observation of participants is a preferred method due to "its potential to gather a wider range of relevant information not accessible by other methods" (Lee and Humphrey, 2006, p. 188).

The authors have also been shadowing some of the business area managers in their daily work when they have been visiting their business areas. During these sessions the authors were allowed to participate in monthly follow-up meetings but also in more urgent meetings due to different problems that occurred in the business areas. The authors participated as passive observers, who were allowed to take notes and to pose questions in-between the discussions. Afterwards, the notes were discussed and written down together with more general reflections.

In business area Primary Care the authors were invited to participate in a leadership course hosted at an external location in southern Sweden. The authors joined one of the scheduled days and participated as observers in lectures, seminar sessions, group discussions, coffee breaks and lunches etc. and were also able to participate in the discussions and to pose questions, both to the group and to individual participants. Notes were taken by both authors and provided a base for discussions afterwards. Thereafter the notes were written down together with general reflections from the course, together with summaries of the discussions that had taken place between the participants.

The authors has also been given access to internal material such as budgets, financial statements, monthly evaluations and comments, access to the business intelligence system with an overview of all entities, quality assessment systems, consultancy reports, written guidelines and manuals, County Council agreements, procurement contracts, tenders, protocols, management comments etc.

3.4 How was the empirical data analysed?

Collection of empirical data, analysis of data and theory development has occurred simultaneously throughout the thesis. The interview material was converted to text through transcription and was then read by both authors and commented on in Word. After the interviews had been read through and commented on, they were complemented with the

additional data sources referred to above. A database with empirical material was built and all material was tracked through the use of Excel, where the three business units and the group as a whole, were given an own sheet. This sheet was then used to keep track of all empirical data from each area and included interviews, meetings, guided tours, documents etc. and where date of registration, name of employee responsible for data, and in those cases where applicable, the duration of the interview or meeting. Through the process of continuously working with the empirical material, together with the tutor, at research seminars etc. patterns in the empirical data started to emerge. In this sense, a standardised procedure for data analysis was not used, and in that sense the process was more “living” than linear, where both theory and the empirical data was worked on in parallel (Dubois and Gadde, 2002; Irvine and Gaffikin, 2006).

3.4.1 Writing the empirical, analysis and discussion chapters

When conducting a case study based on interviews one of the main problems that have been facing researchers have been how to analyse the interview transcripts (Lee and Humphrey, 2006). When writing the empirical chapter in this study, the authors used the framework that was presented in the theory chapter in order to identify technocratic, socio-ideological and interfaces of control in the empirical data. The different management controls that emerged as patterns in the data were then used to determine what to include in the empirical chapter. It could have been tempting to structure the empirics after Alvesson and Kärreman’s (2004) framework, into distinct groups of technocratic and socio-ideological control. However, since this framework is based on the interface between these two categories of control the authors argued that a separation of the data would violate the idea of these controls being interdependent. The conducted interviews together with the additional data sources rendered a large amount of empirical data, and hence, there had to be a selection regarding what data that was necessary to include and what was less important; a decision that was made based on the overall aim of the study.

The analysis was structured based on the different forms of management controls that were identified in the empirical chapter. The theoretical concepts of Alvesson and Kärreman’s (2004) framework were constantly compared to the empirical data in order to identify new patterns, and also to confirm and add to previous research within the field of hybridisation. The discussion chapter that follows the analysis was structured based upon the findings from the analytical chapter and then conceptualised into a five-step model representing the process of hybridisation.

3.5 Research quality: multiple sources and transparency

In the literature it is discussed that there may be drawbacks with conducting case studies and there are many prejudices against the method stemming from the “perceived lack of generalisations and academic rigour” (Scapens, 1990, p. 276). Yin (2009) agues that case studies are generalisable to theoretical propositions and not to populations and universes, and that the goal is not to provide statistical generalisations, but instead to expand and generalise theories. In order for case studies to be able to create generalisable theories there is a need for the researcher to follow systematic procedures and avoid biased views that may influence the direction of the findings and conclusions. In this case the this methodical chapter has an important role to fill in that it allows readers of this study to draw conclusions how this study has been carried out and based on this judgement, if the conclusions may be seen as reliable. Yin (2009) provides some criteria for how to evaluate the quality of research designs, which will be discussed below.

According to Yin (2009) construct validity can be used in order to identify correct measures for the concepts being studied and he argues that there are three tactics to increase the construct validity of a case study. First, the use of multiple sources of evidence can be used to enable data triangulation in the case study. As described above, this study has interviewed employees from three different units, on all organisational levels in order to ensure such a comprehensible picture of the case as possible. The authors have emphasised to validate information through in a discrete manner asking other interviewees to elaborate on the findings from the other interviews, without saying too much. The interviews have been complemented with empirical observations from meetings, guided tours, courses, and written documents about the business. The authors have strived for confirming their findings and patterns from one form of empirical data with as many sources as possible in order to enhance the quality of the empirical material.

The establishment of a chain of evidence is the second tactic emphasised by Yin (2009), which means that the reader of the study can follow in a clearly manner how the results of the study have been derived, from research question to the conclusions. The authors have strived for being as transparent as possible when writing the study in order for the reader to understand the logics behind the reasoning that has led to the final conclusions.

As a third tactic, Yin (2009) argued that key informants should review the drafts of the final report in order to have their view on the analysis and the discussion of the report. The authors have discussed the empirical findings of the study as they evolved over time, with several of the interviewees, in order to have their opinion on the findings. However, it is important to point out that these discussions have taken place in the end of the interviews in order not to affect the interviewees. The authors have also had a close collaboration with their tutor during the whole process of conducting the study, regarding the research questions, the theory chapter and the final analysis. Altogether, the authors have had a continuous discussion with both their key informants at HealthCo and their tutor in order to increase the reliability of the results.

Yin (2009) discusses external validity as a test for knowing if the case study's findings are generalisable. However, as mentioned above, regarding case studies that aim for generalisable findings should focus towards a particular set of results that are generalisable to some broader theory. In this study, the process of hybridisation was applied as the underlying theory for the case study and the findings of the study may be generalisable in relation to this theory. Even if this is a single case study, it consists of three different business areas which may be seen as ”mini-cases” within the case, which at least partly can assist in generating theory without having an unconvincing empirical grounding (Eisenhardt, 1989). However, as Yin (2009) emphasises this generalisation is not automatic and hence, there is a need to replicate the findings of this study in several other private health care companies, where theory specifies that the same result should occur. First then, it may be confirmed if the findings are generalisable or not.

In this section the method applied in the study was discussed. The reasons for choosing a single case study was further elaborated on and the motivation for the private health care company revealed. Further, the collection of empirical data was discussed in combination with the methods used for analysing it. The section ended with a discussion regarding how the quality of the study could be examined and how the findings of the study can be generalised.

4. Empirics

The purpose of the empirical chapter is to provide the reader with an empirical base for the coming analysis and discussion. This section is divided in four different parts. First, HealthCo in general is described and thereafter each business area is described separately. The empirical description of each business area ends with a summary of identified management controls. These management controls were identified from the identification of patterns in the empirical data.

4.1 HealthCo

HealthCo is among the largest health care companies in Europe with operations in several European countries, where Sweden is HealthCo's main market. The businesses consist of operations in several areas of medicine; such as general medicine, surgery and psychiatry. The group consist of several business areas including clinics for varying types of care. HealthCo is headquartered in Sweden where the shared corporate functions for the group are located, such as pay roll administration and some financial functions. However, the overhead organisation is small in comparison to the whole group. Private equity investors own the group. The private equity owners' agenda in combination with the political influence form the purchaser-provider relationship creates an ever-changing environment for the group, or as the CFO puts it:

> HealthCo has short-termed owners and short-termed customers; politicians who want to become re-elected and private equity companies who want to buy and sell. So we have much of an upwards agenda too, not only downwards, it is refinancing each year and business plans crisscrossing.
> (CFO HealthCo)

4.1.1 Quality – in order to win trust among stakeholders

Quality of services is a key value in the HealthCo group and quality is defined as modern medicine, kind treatment, good information to patients and a nice environment with adequate equipment. The quality aspect is emphasised at all organisational levels and is seen as number one priority when operating in the health care business:

> If you design the systems in order to achieve the highest quality possible, then the efficiency usually increases; to do right from the beginning in a well thought out process increases both quality and efficiency.
> (CEO HealthCo)

> …it is important to have such a high quality that is possible and to treat patients in a good manner…
> (Business area manager Primary Care)

> I would never work for an employer who would not emphasise patient safety and quality…
> (Unit manager Geriatric)

> …I think HealthCo has a good quality; otherwise I would never stay in the company…
> (Physician Primary Care)

Quality not only represents a condition for winning trust among employees, it also represents an important factor for wining trust among other stakeholders, such as the county council and the society at large. In order to inform stakeholders about their quality work, HealthCo regularly publish quality reports to inform on the level of quality they have attained in delivered services.

4.1.2 The HealthCo model: quality, productivity and financial return

The importance of quality in the health care services has formed the base for the so-called HealthCo-model, which links together high quality services with increased productivity and financial returns. The philosophy is that you earn money by having high quality, e.g. modern procedures and techniques that increases productivity, and not through savings on things that are vital for having a high quality. The model, which is intended to guide operations within the group, emphasise that quality comes before productivity and financial return, and that quality always should be superior to financial return:

> In HealthCo we based our model on two parts: one part emphasising high quality care, and one part emphasising organisation, reporting and follow-up. When you have to do with such intelligent people, one needs to have a model that they can relate to…
> (CFO HealthCo)

> …I must say that it is fantastic that they have constructed this model and that it is possible to work in this way, that one have decided on the core values (quality) that the model is built upon. In this case I think the CEO (of HealthCo) is a very special person who has seen these things and I wonder were he have learnt this. […] To have this model working in reality instead of just being made up by words, shows that he has listened to the organisation and seen what will work or not, then he has dressed in words the ultimate way of working with health care, when economy and quality shall go together… now it sounds as I praise him, but I am totally honest.
> (Region manager Primary Care)

4.1.3 Attempts to decentralise

Part of the HealthCo-model is built upon the values that the organisation should be decentralised. The top management of HealthCo strive for that the business areas should control their own businesses. Top management's intent is that all managers within the organisation should be able to plan and organise their operations and thus, have full accountability for budgeting and for achieving results. The attempts to decentralise is further reinforced by the fact that the CEO and the CFO does not have a permanent office, instead they regularly visit business areas and clinics to discuss with subordinates in person.

The aim of decentralising is one of the main explanations to why the corporate headquarter is rather small in relation to the size of the whole organisation. When the CEO and CFO joined HealthCo five years ago, they closed down several functions that had been allocated to the headquarters. The consequences were that marketing, purchasing and other "administrative" functions were moved to the clinics:

> You strive for an environment in which the managers that you have know what they are responsible for and were they are close enough to the operations to take decisions. If all resources are centrally located, then it is not the managers out in the daily operations that control their business. Instead there are policies, guidelines, and asking people in different organisational layers before one can take a decision. Our starting point is that the manager who is closest to the business should take the decisions. This requires regulations that are so flexible that you can take decisions that are needed, without creating disorder and confusion.
> (CFO HealthCo)

A consequence of the decentralisation was the creation of several more units with own budget responsibility:

> When I started, we were approximately 50 units, today we are 500 units, since we split the operations in pieces that we follow and measure. A hospital in southern Sweden is still one unit, but with 15 units under it. Five years ago it was only one chief medical officer, one head unit nurse and one manager for the operating theatres. Today we have a manager for each speciality, which are three to four physicians.
> (CFO HealthCo)

4.1.4 Attempts to measure

Top management of HealthCo emphasises that timely measurement of results in relation to the HealthCo-model is important in order to follow the organisation's development and create transparency. Measurement is emphasised both from the top management perspective since they want to be aware of what is going on in the organisation, but it is also emphasised to be used by lower levels in order to understand their units and their potential for development. However, measurement, and especially measurement on an individual level may be a sensitive area when it comes to health care and health care professionals:

> There is a resistance in not wanting to be measured, and one always found an argument for not measuring. But it is better to measure something than nothing; it does not have to be 100 per cent correct. Here comes the intelligence of physicians once more, the more they can, the more they can question everything and then you do not come anywhere, it becomes conservative, it needs to be a mix of democracy and dictatorship. […] When you measure it leads to better precision in an organisation and then also the quality increases. Quality is a prerequisite for productivity and productivity a prerequisite for results.
> (CFO HealthCo)

Coming from the outside without a background in health care has been a challenge for both the CEO and the CFO where they have been required to slow down their efforts to change operations and where they have been forced to step down to learn and achieve trust with the health care professionals:

> No one has taught me how to measure, everybody measures differently. No one has been able to give me guidance for how measurement should be carried out, but I have started to get a picture of how it should look. I cannot walk into a theatre (surgery room) and see what is wrong, and nobody tells me what he or she think is good, but instead I have to force a result through benchmarking. They tell you, but there is no self-propelling force…
> (CFO HealthCo)

4.1.5 Employees of the HealthCo Group

During the interviews performed in this study, it becomes clear that many of the health care professionals, managers and subordinates, have a background from the private health care sector. Some employees had even been running their own health care company before joining HealthCo. In addition, several of the newly appointed managers that have been promoted from a lower organisational level have experience from or interest for working with financial measuring and reporting.

4.2 Primary Care

Table 3. Business area description – Primary Care

Business Area	
Type of health care	Basic
Revenue	MSEK 2 434
Employees	1 685
County Council Remuneration	Pay-for-Service (Stockholm)
Vårdval (Choice-of-Care)	Yes
Complexity of health care	Low
Solitary work/Team work	Solitary work
Outpatients (length of stay<24h)	Yes
In patients (length of stay>24h)	No
KPI	• Visits/Physician • Visits/Nurse • Listed Patients
Unit	
Revenue	MSEK 20
Employees	17

Business area Primary Care consist of 73 primary care units found at different locations in Sweden. Primary care units take care of patients with diagnoses that are not acute and either can be treated directly by the unit or needs to be sent with remittance to a specialist clinic or hospital. The primary care unit studied in the present thesis is located in the Stockholm County and operates under an agreement with the County Council of Stockholm. This has consequences for the reimbursement model and consequently it operates under the Healthcare choice reform, which is designed as a “pay-for-service” model where the primary care unit receives reimbursement for listed patients and for each patient visit up to 1,9 visits per patient during a 12 month period. Over this limit, the unit is still obliged to take care of the patients but without full reimbursement.

Historically, business area Primary Care has been an unprofitable part of HealthCo and it was first towards 2012 that it started to report positive numbers. The business area manager remembers when the new CEO joined HealthCo and decided to radically change the business area:

> In the autumn of 2009, something happened that I had never experienced before; my boss got fired and was given three hours to leave his job. The new CEO of HealthCo turned the entire Primary Care business area upside down, the unit managers became managers, and they were to become skilled. Before, they had been managers for the health care professionals, but not for the physicians. The financial reporting was based on whole regions with all costs accumulated, nobody knew if the result was good or bad, nobody knew the numbers, nobody could be accountable since one did not know anything. The new CEO took everything apart and created own units…what he wanted was transparency and to give the individual unit manager responsibility.
> (Business area manager Primary Care)

When the business area was reconstructed in 2009, the reconstruction was met by resistance among the unit managers. The transparency created by the changes was seen as a threat to their autonomy. However, despite initial resistance, the push by the management for change eventually resulted in acceptance among unit managers:

> I got a new CFO and together we went out to deal with the numbers. We taught the unit managers to think in numbers and how to understand the numbers. […] I was very criticised for my leadership, they wanted restrictions and they wanted me to say how they should do it. I always said 'yes I could do that, but I won't'.
> (Business area manager Primary Care)

4.2.1 Organisational structure

Each organisational level within the business area rests upon three different "legs":

> The whole organisation rests upon three different legs: the medical leg, the operational leg and the financial leg. That is the organisation on all levels, from the primary care unit, through the regional level, to the business area level. No leg can be longer than the other, then the chair tips over.
> (Business area manager Primary Care)

> All legs need an equally stable pressure in order to have a stable business. Generally, when we have a problem, it is usually because one of the legs. Then you need to find that leg and focus on what to do to solve the problem, if it is a medical problem then it is a case for our Chief Medical Officer and so on… These three functions must exist on all levels, even on a single primary care unit were we have the Medical Responsible Physician who is responsible for the medicine, the unit manager who is responsible for the operations and the controller who is responsible for the financials.
> (CFO Primary Care)

The administrative professionals of the Primary Care business area travel frequently to the different units for local financial follow-up or other issues that needs the attention of the management. The model is that the administrative professionals always visit the units and not the other way around. The business area manager who emphasise that she does not have an office since she is always travelling between units has been said to take "operationality to absurdum" (business area manager Primary Care). When visiting units she travels by public transport, says hello and talks to all personnel at the units, not only the manager. When meeting health care professionals she tries to call for questions and emphasise that they should tell her what is upsetting them or if any one wants to question a decision. She listens

carefully for input and at the same time as she emphasise that she stands for decisions taken. Due to her background as a nurse she can explain her experiences from the same medical problems that the health care professionals experience and at the same time move the discussion to combine medical practice with financial results and KPI[4]'s.

4.2.2 Primary Care units

The typical primary care unit consist of a unit manager who often has a nursing background. An exception is one primary unit in which a former HealthCo marketing director has taken on the role as manager. The fact that this unit manager does not have a health care background is seen as very unique among the health care professionals in HealthCo. In those units in which managers do not have a medical degree, they are obliged by law to have a Medical Responsible Physician who is responsible for decisions regarding medical issues. The unit manager is responsible for the daily operations, staffing, investments and budgeting:

> I do my budget based on guidelines and our agreement (the County Council agreement) and I sit down together with my controller. She looks at how many patients we have listed and then we do the calculations together. Thereafter I have free hands, but again, the County Council agreement stipulates what we should do and that I need to follow.
> (Unit manager Primary Care)

> If I want a microscope for ears, which I think that we need, it will cost SEK 50 000 – 75 000 and since everyone has its own budget one needs to evaluate if it is really what we need.
> (Physician Primary Care)

> If you are responsible for your business, then it is very good if you tell what you want to do with it. […] We want budgeting to be something positive, where one talks about what we should do next year. What are you going to do in order to succeed with your business? I could do a budget that probably would be twice as good, but it would not mean anything since I cannot fulfil it […] it is first when you have some form of commitment, that you shake hands on the budget and then you feel it in your stomach, now I have taken on responsibility for something, I have received faith in doing this. When you have faith then you can solve almost everything, when it disappears then we have a problem.
> (CFO Primary Care)

4.2.3 Collaboration between managers and controllers

The financial work is carried out in close relationship with a controller who supports the unit manager when it comes to financial planning. The unit manager and the controller meet at least once a month in order to discuss the financial outcome and the quality parameters that are part of the county council agreement:

[4] Key Performance Indicators.

> The unit managers receive everything in a monthly package, and they can also follow the numbers in the business intelligence system. The first thing they receive is the ID-card (a dashboard with financial measures) which they enter into and write comments regarding the financial result and that is were I come into the picture and discuss why the numbers look as they do and if they have questions then we go in together and check the numbers.
> (Controller Primary Care)

Each primary care unit has an own controller who acts as a support to the unit manager and is not accountable for the financial result:

> If I see a cost number in the financials that is far too high then I dig in and start analysing it, but otherwise it is usually on the unit managers request, they are the ones who control and they are the ones who take the final decision. I can come up with suggestions that I think that they should do, but then in the end they have to decide what they want to do.
> (Controller Primary Care)

Accountability for the financial outcome on a monthly basis and the freedom to plan the services are new responsibilities for the unit managers who admit that it sometimes is a difficult task. This has resulted in unit managers requesting education to increase their financial understanding.

> I would like to have more financial perspectives on things, since I am not so good at economy, I can read numbers, but I would like to draw conclusions and become more proactive. We write ridiculous comments in the ID-card today, I would like to write better comments regarding why something have happened and what I can do about it.
> (Unit manager Primary Care)

> It is about being there and talking with them (unit managers) about stuff that is not strictly financial. You must increase EBITDA with 15 per cent, then they just sit there and stare and look unappreciative. 'What should I do then?' They do not understand. Or, you need to improve your operating capital, 'aha, ok, how do I do that?' However if you instead say: 'do you think that your physicians can take one more patient per day, would it be possible?' 'Yes, of course, no problems!' So, you do not speak in those terms (the financials), instead you speak of hours per physician, nurses per physician and so on, since this is what is mirrored in the income statement. The income statement for an economist is in fact just the sum of everything else.
> (CFO Primary Care)

Apart from guidelines and the County Council agreement, the unit manager has a free hand to organise and plan the daily work, as they prefer. They may also initiate and implement projects and systems for quality follow-up and financial measurement and also construct own KPI's. They can receive help from the administrative professionals with these tasks:

> I just received a phone call from a unit manager who had a problem with short-term illness among the staff and wondered if it was possible to construct some kind of variable pay system for when they stand up for each other, instead of leasing staff. Then I am with them and give support in this specific case.
> (CFO Primary Care)

4.2.4 Performance measurement and transparency

All business units have a program for profit sharing that falls out if they reach and exceed the operating margin and if the county councils quality parameters are met. The transparency of the financial reporting is high and production and productivity can be tracked on an individual basis, which results in a low level of anonymity for the employees. The unit manager review the production and productivity measures on a daily basis:

> I am following the amount of patients that calls us each day and I want the physicians' calendars to be full, it is the duty of the reception nurses to fill the gaps with patients if there are any, and in such a case they need to call in patients.
> (Unit manager Primary Care)

Individual physicians are also able to track the productivity of their colleagues:

> Yes, it is possible to look into each other's appointment register and they do that, it is a competition between them and also to see if they can help each other.
> (Unit manager Primary Care)

The transparency in combination with monthly follow-ups with the health care personnel at the units is also an important part when it comes to building trust between the health care and the administrative professionals:

> I think everybody want to know (regarding the financial result). However, everybody would not be happy if they saw that there was a large profit that was not returned back to the unit. […] The physicians and nurses would protest if they saw that we generated a profit of 40 per cent, and then they would question why they should take so many patients in order to generate a profit for HealthCo. Now we can explain that this is how much money that is over each month and that should be used for reinvestments, and that the owners should receive something for having bought the company. But if there were profits that we could not explain… then they would not feel involved anymore, why should they work hard if they are not given part of the profits?
> (Region manager Primary Care)

> … one thinks that we work really hard and still the result is negative, then you want to know why, is it due to leased personnel or not? If you (the unit manager) are clear about this and tell us, then the personnel understands and everybody are at the same starting point.
> (Physician Primary Care)

The values in delivery of secure, professional and qualitative care services permeates the business area as common goals and is seen as a presumption for generating a positive and long-term financial result:

> Yes, when the quality targets (tied to remuneration) are achieved, when we have good patient surveys and employees that thrive, then it is probably not that important to be best when it comes to the money but it should be an economy in balance, in that case the medical comes before the economics. […] But it is exciting to see how you can decrease it (the costs) since I want an economy in balance and then you need to look into the small parts. I do not see it as quality to have thousands of different bandages; you should always dig in and investigate on a detailed level.
> (Unit manager Primary Care)

Quality in primary care can be defined in numerous ways and is often derived from the values of the health care professionals. In some cases the values of what constitutes quality are influenced and substituted by external factors:

> We are not able to always deliver the highest quality as we would wish […] there are recommendations from each County Council that we are told to follow, it is not always the drugs that one would wish, since there may be other drugs with less side effects but that are more expensive. If we start to prescribe too much of these, then we will probably be fined or loose the bonuses from the County Council.
> (Chief Medical Officer Primary Care)

This shows that the county council agreement may actually make health care professional somewhat violate their professional values. Health care professionals consider that the county council has legitimacy to determine and change the boundaries of quality.

4.2.5 Financial Pressure

The health care professionals has experienced a change during recent years, from the belief that the resources are endless to a more economic thinking were everyone are aware of what a long-term bad financial result or bad quality measures can cause:

> The primary care unit needs to reach break-even, otherwise there is risk for layoffs and that have occurred during all years, back and forth…
> (Assistant nurse Primary Care)

> In the public sector you do not really know the performance, it does not hurt as much or is as visible, if we have a primary care unit that delivers red numbers it may result in that HealthCo decides to close it. This will happen now when we close a unit in southern Sweden. […] This will be communicated to the rest of the group. […] Then you need to decide that enough is enough and that is also a way of showing responsibility. It is not okay to continue with leased staff, poor care and no continuity.
> (Business area manager Primary Care)

4.2.6 Training – Off-site leadership course

Newly appointed managers on all levels of business area Primary Care are requested to participate in leadership training. The aim is to provide the managers with leadership tools and give them advice on how to manage their colleagues. The majority of business area Primary Care's managers are recruited internally to a position hierarchically above their previous clinical role. The training is directed to managers but also deputy managers, who have shown an ability and interest to take on a full leadership role in the future, are invited. The training is well known within the business area and it is seen as a privilege to receive an

invitation and thus, a signal that management has seen you. Each course consists of three sessions that are two days each, which makes a total of six days of training, spread over one year. An external company is responsible for the training, but targeted to suit the needs of HealthCo. However, in many senses the courses do not make any difference between leadership carried out in a health care company compared to a company that is operating in another business and is in that sense rather generic.

The course is hosted at a luxurious hotel in the countryside of southern Sweden and the participants are given accommodation, three course meals and access to spa facilities for free in addition to the course. During the sessions, the participants are seated in a semicircle and the teaching is conducted in an interactive manner including group discussions and project work based on real life issues from the managers' units. Between the sessions they are given different tasks to work with, reflect over and even implement before they meet again. It is emphasised by several former participants that the open and friendly atmosphere have created strong networks among them; networks that have continued to exist well after the course has finished. Several of the former participants continue to meet and eat dinner together or call each other over the phone. The networks are partly used as a forum for knowledge sharing and discussions tend to cover operational issues that the managers have encountered in their units.

During one of the sessions, the 13 participants were given the task to discuss the nature of their leadership. The discussion took its starting point from the four aspects of behaviour in a DISC-assessment[5]. The four aspects were then divided into two groups; one consisting of *dominant* and *conscientiousness*, and one consisting of *influence* and *steadiness*. The former group was summarised with the word *brain* emphasising a calculative and result driven behaviour. The latter group was summarised with the word *heart* emphasising caring and humility. It was concluded that health care professionals in general are more heart-sided than brain-sided meaning that health care professionals are generally more caring than result driven in their profession. A discussion followed regarding the responsibility to also include the brain–side of leadership in the managerial role, as the leadership also involves a commitment towards the owners of the company. Thereafter a discussion followed on how you as a manager can act on the basis of both these perspectives:

> The perspective of the heart should always guide us in our decisions, and therefore all decisions that are taken from the perspective of the brain should be based on the perspective of the heart.
> (Participant 1)

> In my opinion, if you are too much of a brain-person when it comes to your leadership and only focus on the money, then that would not be good for the operations.
> (Participant 2)

[5] DISC is a behavioural instrument that can be used as a tool for personal assessment in order to improve work productivity, teamwork and communication. DISC helps people discuss their behavioural differences through the determination of four different personality types: *dominant, influencer, steady* and *conscientious*. For a more detailed description of DISC (see e.g. Discprofile, 2013, Slowikowski, 2005).

> Of course not, one needs to keep in mind that the staff is heart-people and that you need to always take this into consideration in your daily decisions.
> (Participant 3)
>
> Yes, I agree with you. I would also want to add that you need to use different roles in your leadership when it comes to merging the philosophies of the brain with the philosophies of the heart and it is important to keep in mind that some staff take longer time to understand how these two philosophies can merge in a health care setting.
> (Participant 4)
>
> I would like to add that there is a risk of becoming manager since you adapt to the values of the manager in a privately owned company (brain) and how such a manager should behave, with the consequence that you supress the core values of the health care organisation (heart), which may result in confusion and frustration among staff.
> (Participant 5)

After the discussion above the participants were asked to rank how large part of their decisions that were based from the perspective of the heart versus the perspective of the brain. The majority answered that approximately 70 per cent of their discussions were based on the perspective of the heart and that 30 per cent of their decisions were based on the perspective of the brain.

Table 4. Summary of management controls present in business area Primary Care

Control	How used	Implication
Organisational structure	• Medical, operational and financial roles on each organisational level • All professions are considered equally important for performance	• Operational managers gets both medical and financial support • Barriers between professions are lowered
Budgeting	• Bottom-up budgeting of output and input measures • Decentralised ownership	• Ability to affect the budget based on own values of how health care operations should be managed • Sense of ownership and accountability for results
Reporting	• Transparent and monthly reporting in relation to: o Budget (transparent from individual physician to group level) o County Council quality parameters (tied to remuneration) • Requirement to write comments on financial output	• Health care professionals are questioned about the financials, which in turn push them to learn about the financial implications of health care. • Creates an interest for engaging in the financials among health care professionals
Socialisation	• Quality is emphasised in standards and models • Quality is considered superior to cost • Managers on all levels emphasise that the competence is in the front-line of the organisation	• HealthCo's quality focus is in line with the values of the health care professionals, which results in their acceptance of technocratic controls
Recruitment and Promotion	• Recruitment and promotion of individuals that has experience from e.g. financial reporting	• Staff that are more experienced with working with financials can act as ambassadors for hybridisation within the organisation
Training	• Formalised standards for leadership training • Signals that it is important to invest in the front-line managers	• Employees feel that they are being recognised and invested in • Creates openness to technocratic forms of controls
Networks and Meetings	• Training • Follow-up meetings • Regional meetings	• Health care professionals can share operational and managerial experiences • Creates a common culture and a sense of belonging to the business area • Lowers barriers between professions and open up for communication • Knowledge sharing between professions and organisational levels

4.3 Geriatric

Table 5. Business area description – Geriatric

Business Area	
Type of health care	• General geriatric care • Stroke rehabilitation • Orthopaedic rehabilitation • Acute care in the home (ACIH) • Palliative care • General rehabilitation
Revenue	MSEK 360
Employees	390
County Council Remuneration	Procurement/Pay-for-Service (ACIH and Palliative care)
Vårdval (Choice-of-Care)	Yes/No
Complexity of health care	Medium
Solitary work/Team work	Team work
Outpatients (length of stay<24h)	Yes
Inpatients (length of stay>24h)	Yes
KPI	• AVLOS (average length of stay) • Rehabilitation efforts (DRG-points) • Number of inpatients • Number of outpatients
Unit	
Revenue	MSEK 41
Employees	42

Business area Geriatric in Stockholm specialises in the treatment and rehabilitation of the elderly and is carried out at a hospital in the Stockholm County. Several of the patients have multiple illnesses and function impairments. Geriatric's 24 units are spread across the following areas: general geriatric care, stroke rehabilitation, orthopaedic rehabilitation, acute care in the home of the patient (ACIH), palliative care (care for dying patients) and general rehabilitation. The main parts of the business operate under procurement contracts in which reimbursement is connected to amount of diagnoses and rehabilitation efforts during the care episode. This business is contracted for a maximum level of reimbursement; thereafter the unit is still obliged to take care of the patients but without any reimbursement for the care. The ACIH, palliative care and the general rehabilitation operate under the Healthcare choice reform where reimbursement is connected to the volume of patients without any maximum reimbursement level.

4.3.1 When Geriatric won the procurement contract

When Geriatric won the procurement contract in 2009, the CEO and controller of Geriatric realised that there was a need for an increased production within the business in order to meet the targets:

> When I started here (at the Geriatric business area) I started to talk production immediately and it took a while before it worked, in the beginning I was quite unpopular 'since here you do not talk production, you talk about human beings', I do not se any contradiction in that and tried to explain that we need to talk about it in those terms (production). […] It was the physicians who opposed… We did not change in order to have results that were common and official, but more since we wanted a more sharp discussion with each unit… In the beginning we simply worked with a lot of numbers.
> (CEO Geriatric)

> We worked a lot with the fact that we had won this contract from the County Council and this is how much care we need to provide, then we only talked production the first three months. We did not talk any quality at all, instead we took it for granted and then we repeated it (production) constantly and then we reached our targets. […] It is in the agreement with the County Council (the production), if we cannot manage it, then a lot of patients will be left at the acute hospitals without the care that we should have given them, this is the most important part in this discussion.
> (Controller Geriatric)

4.3.2 Organisational structure for Geriatric

Each unit within the business area has a dual leadership that is split between a head unit nurse and a Medical Responsible Physician, which form the unit management. The head unit nurse is responsible for all health care personnel except the physicians. Within this mandate comes responsibility for planning of the daily operations and budgeting of costs, where the largest part accounts for the health care personnel. The Medical Responsible Physician is responsible for discharge of patients and regulates the flow of patients through the unit and thus the production. This mandate comes with responsibility for the production. However, the Medical Responsible Physician is not responsible for the physicians, instead all physicians report directly to the Chief Medical Officer in the business area:

> Within health care you may have a head unit nurse who is manager for the physician. That is the case at certain places but it is hard to be manager for someone with such a large influence. It could be hard to be manager for someone with another wage scale, thus someone with more salary than you. […] The physician is unwilling to be manager and wants to work clinically, which is why you have the dual leadership. It is a delicate situation were one is mutually dependent of each other, though one cannot control each other, and each one reports to different managers.
> (Controller Geriatric)

> Business area Geriatric has an organisation similar to the County Council's own organisations, where you have physicians with a chief medical officer who does not have any responsibility for profits and costs, thus with the only responsibility of being manager for the physicians, then the physicians work somewhere else in the organisation, this is a question about tradition and the maturity of the management team and the willingness and strength to take the conflicts.
> (CFO Business area Geriatric)

4.3.3 Performance measurement

When it comes to budgeting within the units, the dual leadership has consequences for the process:

> The budgeting process as such is a discussion with the single physician, however, Geriatric being an exception since it is so large that the physicians have the possibility to be a little more anonymous… it is not a catastrophe if one or two physicians are sick one day compared to a primary care unit were half of the production resource disappears in that case.
> (CFO Business area Geriatric)

> We (head unit nurse and Medical Responsible Physician) sit together and look through the guidelines for budgeting. There are guidelines for staff, laundry, food, and care material. When it comes to laboratory, drugs and x-ray then the Medical Responsible Physician is involved and approve the invoices, but I am the one who pays. Then we have a follow-up each month. I have a budget for staff, however, I can decide how many positions we should have, and thus, I can have more or less positions depending on employment level.
> (Head unit nurse Geriatric)

However, the unit management is not provided with comprehensive information regarding the financials since the administrative professionals are afraid of disturbing them with too much numbers:

> We rarely show the income statement… We do not show so much […] I have noticed when I distribute the income statement to the head unit nurses that they tend to focus on 'how can the cleaning services be that expensive?' and that is stuff that we cannot change, there are a lot of costs that we cannot control and they become frustrated over it […] We try to show them such things that they can control […] …if we show them (the health care professionals) the financial result that we generate, this may lead to questioning regarding 'why should we run so fast and HealthCo generate such a profit?'
> (Controller Geriatric)

The administrative professionals want the health care professionals to focus on the actual operations rather than being too involved in the financials:

> I am the one who develops KPI's for the units, the unit management does not do it but they may come with comments […] They (the unit management) understand quite a lot but one may question how much they really should work with the financials, they should have thorough control on their costs and their production, but they do not need to be able to read the income statement […] We focus on that if it is good (the financial outcome) then we do not need to show it… They are interested but we have chosen the other way of not showing the result…
> (Controller Geriatric)

> We have so many numbers, so many measures regarding for example bedsores and such things so there we can notice our efforts in the measures, but it is harder to notice our efforts in the financial measures…
> (Nurse Geriatric)

The controller emphasises that the unwillingness of giving away too much financial information is a way of keeping control and avoiding too much decentralisation:

> We have quite good control over the operations and the Chief Medical Officer is out there all the time, but now when we have been acquiring new businesses then we have not been here as much as we use to, that is negative, we do not have the same control and staff do not think that we are as present as before. […] We need control, the most of the units manages themselves but they want continuous feedback that they are good, they want to hear it from the CEO of the Geriatric and they want to hear it often.
> (Controller Geriatric)

4.3.4 Divergence between health care professions

The physicians, however, are and have historically been reluctant to be involved in the financial work:

> Usually they have different roles (the head unit nurse and the Medical Responsible Physician) that should accompany each other […] they should work together, but it is often the head unit nurse who is the driving force.
> (Controller Geriatric)

> I can speculate in that one may think that we are a little too noble to talk money, we prefer to keep within our medical guild, we are specialists in medicine, we are here for the patients, and we do not want to prioritise among the patients.
> (Chief Medical Officer Geriatric)

> Physicians have historically fended of the financial with the values that it constrain us, but I think that if we have control over the economy, then I can distribute the resources among the patients who need and those who do not need, it is not more difficult than a household budget. What is difficult is to convey this across my colleagues, 'now we do too much, is it really necessary?' It could be a delicate matter since physicians by tradition have been sovereign in their judgements.
> (Medical Responsible Physician Geriatric)

This unwillingness to address financial issues may have its roots in that the physicians do not see it as part of their role at the unit:

> The physician has during a long time been as a consultant working at the unit, do what he/she is supposed to do and then leaves, it has had advantages in that you avoid conflicts and that you leave walk-over to other professions, as the nurses who were wise enough to take on the management role. It was so bothersome to deal with leadership issues that the physicians pulled out. Then one has placed oneself outside (the organisation) and taken on a victim role, and it is quite undemanding to take on a victim role and complain, instead of trying to implement changes and stand up for them and then realise that the change in itself was poor and need to be changed; it is more demanding to enter into the actual processes.
> (Medical Responsible Physician Geriatric)

Another circumstance that may have influenced the physicians in their decision to stay away from the financial work may have been the organisational structure:

> Yes, the head unit nurses do it (investigate the monthly outcome), but we still have a matrix organisation were the physicians take care of their part and the units take care of their part, it has been hard to involve the physicians if I am to be honest […] they tend to be unwilling to listen to anybody else than themselves. The physicians are not always participating at our unit meetings; it is just recently that they have started to participate more frequently at our 'lean' meetings. From the beginning they thought that they did not need to participate. They are an important part but they deemed that it was not medical issues that were discussed, but if you are not there then it will certainly not be any medical discussion at all.
> (Medical Responsible Physician Geriatric)

4.3.5 Profit, a sensitive subject

The Geriatric has a system for profit sharing based on the financial result, where all employees obtain the same amount of bonus, irrespective of their profession. However, when talking about increasing efficiency within the business area, several of those interviewed mentioned that it is impossible to use terms such as 'profit' or 'return' since it may collide with the values of the health care professionals:

> We usually end up in discussions 'why can we not employ two more nurses instead of generating 9 per cent profitability…' We had a lot of these discussions in the beginning why we introduced the model for profit sharing were one third of the profit above a certain level goes back to the employees […] If HealthCo generates a profit and part of it is returned to the employees, then it is okay… It may be more difficult if we have a large workload and one may think that we should lower the profit margin. Then we respond and say that if we have the same staffing with the same quality as other geriatric clinics then we think that the margin is fair, it had been worse if we were five employees less than the other clinics…
> (Controller Geriatric)

> I never ever speak about profits, whatsoever…
> (Head unit nurse Geriatric)

The CEO, controller and the Chief Medical Officer are part of a separate program for profit sharing, which is based on the financial result of the business area, a system that they rather not talk about in the organisation:

> This is a very sensitive issue, I would never be able to mention it internally, it is so sensitive…
> (Controller Geriatric)

> I do not know if I can answer that question, I am serious. Did the CEO really answer? In such a case I answer the same as the CEO. This is actually extremely sensitive… there is a lot of energy in that word (bonus).
> (Chief Medical Officer Geriatric)

4.3.6 Pressure for change

It is hard to measure the individual contribution of employees within the main parts of the business area since services are performed in a team setting were an individual patient may meet 30 different employees during the stay. However, in certain units there has been a move to measurements at an individual level:

> We have had production problems in one unit…where we conduct ACIH, which means that we move the resources of the hospital to the patient's home, where we conduct palliative care and prepare patients and their relatives for death. […] In this unit we had problems since there are so much care carried out in the patients home, which means that the operations are quite hard to control, 'how long should a visit with a dying patient take?' […] When I talked to the physicians then they said that 'it is so special so you will not understand', and I understand that it is special but at the same time it was a protection for not having these types of discussion […] Then ACIH and palliative care became part of the Healthcare choice reform so that the patients could choose on their own, and then we said (the administrative professionals) that now it is a question of either winning or disappearing […] Then we started to measure on an individual level how many visits each physician or nurse conducted, this was not done in secrecy and the employees could compare with each other. We saw big differences among the physicians and nurses that could not be explained by more difficult patients. We managed through using the Healthcare choice reform as a threat, there was disagreement but it was very effective, then one realised that it was serious.
> (CEO Geriatric)

There have also been other pressures that have forced the health care professionals to initiate measuring of the operations:

> We have competent and professional staff but lack the philosophy (of measuring results) and the answer to the question how I should reach out to them is probably by emphasising patient safety, the patient first, that is something that one understands, in that sense high amounts of bedsores is a gift from above, last autumn we had high amounts of infections, suddenly you can start talking about it, now it is serious, we stand out in a bad way, then you start analysing and discussing and you get a really god commitment as is the case when you talk the same language… now we register top-values and have decreased the amount of infections […] Patient safety is a language they understand and that they think is a little noble…the problem is that some colleagues interpret safety as doing everything twice, which in turn creates uncertainty… then I need to write standards in order to regulate the work and remind them of deviations from these.
> (Chief Medical Officer Geriatric)

Having all physicians reporting to the Chief Medical Officer has created rather slow decision making, unclear responsibilities with following accountability and a large amount of stress. Therefore the Chief Medical Officer decided to change the organisational structure, although no visible pressure motivated this change:

> The organisation of the physicians is going to be changed into sections where a couple of units are clustered together to a section and where the section manager reports to me […] I said that we were going to do this change one year ago and then my idea was to let the physicians become accustomed to the change. In practice it does not work like that, it is better to do things fast, now the physicians have been worried for over a year […] They are worried for coming too far away from the management team, they are used to have a direct line into management. However, with the new organisation, I will become more accessible and can spend more time out in the business, which will benefit the physicians.
> (Chief Medical Officer Geriatric)

4.3.7 Describing health care with the words of accounting

The administrative professionals admit that they need to develop and refine their language when they communicate with the health care professionals:

> If I as an economist just talk production and numbers then I am not trustworthy, if I can say that I understand why the production is lower due to an issue on the quality side as infections, then it is easier to be trusted…
> (Controller Geriatric)

> We are guided by the procurement agreement, which is described in DRG-points which in turn is a complicated measure that varies over time, and they are closely linked to money, at the same time it is an incomprehensible number for the staff, that we should produce 63 DRG-points each month. After some time we saw a good correlation between DRG-points and the amount of care episodes, so we said okay, we report DRG-points to the purchaser, but we never communicate it internally, instead we communicate care episodes which is much more apparent for the staff and can be measured every day. If the staff does not understand in which direction you should steer, then you are lost quite fast and we have a bad dialog with the staff. We have to give them measures that they can understand, measure and evaluate on their own and steer each other during the month so that you do right, otherwise we will still be the ones that are controlling.
> (CEO Geriatric)

> In the beginning at our meetings we discussed most hard facts, number of patients that passed through, different measures, and costs. Slowly we started to discuss questions of a more medical character and they are sometimes given more focus than the strict measures, which is good. A circumstance is that the measures need to be in place in order to be able to discuss. However, it is still hard to have the physicians to understand that it could be in our interest to be involved in the financials and the control, since it gives us influence, but we will also have to accept that we are in a situation were we cannot decide everything.
> (Medical Responsible Physician Geriatric)

4.3.8 Communication of quality

The units operate under a balanced scorecard that is developed by top management as a complement to the budgetary guidelines:

> We have a balanced scorecard with patient, process, economy, and employees as main areas, where we decompose and implement measurable operative goals each year and where we try to vary the operative goals from one year to another… this year we have added care related infections.
> (CEO Geriatric)

> I would not work here if the values that HealthCo stands for did not match my own values. […] One at least partly find evidence that the values are more than a paper product since they are reflected in our balanced scorecard, managements' communication, and their way of listening to us (the health care professionals)…
> (Head unit nurse Geriatric)

When the CEO and controller of Geriatric for the first time met the CEO and CFO of HealthCo, they were to have a discussion of the budget for next year. However, at this point in time the Geriatric area had been reporting the shortest care times in the Stockholm County; the controller remembers how the budget discussion was left out of the meeting:

> He (the CEO of HealthCo) questioned how it could be possible that we had the shortest care time in Stockholm, and wondered if the short time could possibly threaten the quality of the care…the focus of our discussion was no longer the bottom line, instead we spent time to prove that we had the highest amount of rehabilitation efforts in Stockholm County, and that even if the time of care was short, the patients received their appropriate care. It is clear that the CEO (of HealthCo) is not satisfied with only financial results, instead he wants us to have good quality numbers and that we can be proud of the care that is delivered.
> (Controller Geriatric)

4.3.9 Attempts to reduce the professional groupings

Involvement of the health care professionals has been emphasised by top management in order to integrate these both groups. When the business area was to write a tender for a new procurement process, the CEO of Geriatric chose to hand-pick 20 health care professionals on varying levels to join the administrative professionals in the process. According to several of the interviewees at Geriatric, this was viewed as a positive way of including the health care professionals in the administrative work. The CEO remembers:

> I invited them to join us and I said that now we are to write a tender and I want you to be with me to properly describe our business and what parts that we can do better than today, and if we win I promise you that I will invite you all for dinner. […] When I met an employee on the parking lot after she had been on vacation for two weeks and the first she said was 'I have thought about that we should write about our safety-receipts in the tender, it is important to mention', then I had it confirmed that she was with me and wanted to win the procurement… it is important to involve the staff and trust in their gut feeling.
> (CEO Geriatric)

Management has also introduced so called leadership forums for discussing medical, economical and staff issues and knowledge sharing. These forums are also an attempt to stimulate a dialog between professions and between top management and the units.

Table 6. Summary of management controls present in business area Geriatric

Control	How used	Implication
Organisational structure	• Organisational structure which separates physicians from the rest of the health care professionals • Dual leadership structure	• High barriers between physicians and remaining professions
Budgeting	• Partly decentralised budgeting process which only includes a selected number of cost items • Head unit nurse has a larger responsibility for the budget in comparison to the Medical Responsible Physician	• Head unit nurses have an ability to affect part of the budget based on values of how health care operations should be managed • Low barriers between health care professionals excl. physicians and administrative professionals • The physician's ability to affect the budget is limited since production, which is their main responsibility, is relatively fixed
Reporting	• Head unit nurses are followed up monthly on staff expenditure and medical responsible physicians are followed up monthly on production • The unit income statement is not shown and the unit management are not required to write comments on performance • Split reporting emphasises different financial responsibilities among unit management	• Head unit nurses have a tighter connection to the financial work since they are responsible for a larger part of the budget • The production is relatively fixed and hence the medical responsible physician has a more passive role working with financial reporting
Socialisation	• Quality emphasised in standards and models • The CEO and the controller engage in a socialisation process with all health care professionals except physicians • The Chief Medical Officer engage in a socialisation process with the physicians	• The socialisation process is two-part which results in a gap between the physicians and the remaining health care professionals/administrative professionals • Managements' socialisation efforts does not reach the physicians
Recruitment and Promotion	• Recruitment and promotion of individuals that has experience from e.g. financial reporting	• Staff that are more experienced with working with financials can act as ambassadors for hybridisation within the organisation
Networks and Meetings	• Leadership forum • Follow-up meetings • Workgroups for procurement • Emphasise the importance of everybody and knowledge sharing	• Health care professionals can share experiences from operational and managerial implications • Attempts to lower the barriers between professionals and open up for communication

4.4 Artro

Table 7. Business area description – Artro

Business Area	
Type of health care	Orthopaedic clinic specialising in arthroscopic surgery, sports injuries and rehabilitation
Revenue	MSEK 125
Employees	63
County Council Remuneration	Procurement/Pay-for-service (rehabilitation)
Private health care (Insurance etc.)	Yes
Vårdval (Choice-of-Care)	No
Complexity of health care	High
Solitary work/Team work	Team work (one physician per surgery)
Outpatients (length of stay<24h)	Yes
In patients (length of stay>24h)	Yes
KPI	• Worked clinical staff hour/Physician hour • Theatre utilisation • Sales/Physician hour • No. of outpatients • No. of inpatients
Unit	
Revenue	MSEK 72
Employees	25

Business area Artro in Stockholm is a clinic with specialisation on orthopaedics focusing on arthroscopic surgery, sports injuries and rehabilitation. With a history dating back to 1992, long before HealthCo was founded, this business area was a part of the deal when the HealthCo group was established. Artro offers highly specialised medical care and rehabilitation for complex injuries. The aim has been to specialise on a certain part of injuries, focusing on high volumes and thus becoming specialised and skilled in these specific surgeries. The business area is also involved in orthopaedic research efforts and has a joint venture with one of the larger academic institutes. Artro has also been the initiator to different quality registers in which patients are followed up after they have received surgery. 50 per cent of Artro's patients comes from the procurement agreement with the County Council, 30 per cent of the patients are sent by insurance companies or patients who pay their own care, and the remaining 20 per cent comes from the other County Councils within Sweden. The procurement agreement with the Stockholm County Council regulates the price for different surgeries and the pricing depends on some surgeries being more profitable than others. Some are even a financial loss for Artro. Today, the business area stands in front of a challenge by probably entering the Healthcare choice reform. The price list for surgeries will probably be even lower than today's remunerations, which will result in a higher pressure on the business area to adapt the business, or lower its profit margin. The insurance patients and the private patients are fare more profitable, however, but the volumes vary over time and these surgeries are harder to schedule on a regular basis. Artro has been operating as a freestanding unit since the beginning:

> We are our own unit and has always been, I have been fighting for that, I am a little more of an entrepreneur and I have survived all these years… We were three physicians, who started this clinic with focus on arthroscopy and sports injuries, I am an orthopaedic surgeon from the beginning. We were lucky since a new house with a new clinic was built and the DRG-system introduced, with DRG we were freed from budgets and we were free to do what we wanted. We built our own clinic, built our own IT-systems, focused on good information to the patient and a delivery of good care. Since the business was mispriced in the DRG-system, we earned a lot of money…
> (CEO Artro)

The entrepreneurial heritage of Artro in combination with a strong CEO and the relatively narrow specialisation has made Artro an independent unit in the HealthCo group, which is recognised in different perspectives by the staff of Artro:

> We are an own part of HealthCo, where the distance between HealthCo and us is a little longer.
> (Unit manager Artro)

> We are probably more distanced from HealthCo, the only ones who work with them are the CEO and the controller, and sometimes somebody visits us, I have joined them now and then. You sit with the Excel sheets and then we add something there and then the result is this, it is so much playing around with the numbers, but it is so much more complicated than what you see in the numbers […] I think that we are an independent business area and has always been, perhaps a little too independent…
> (Physician Artro)

> Artro is not even a spin-off from HealthCo; it is a totally cut-off… far away from the rest of the business areas.
> (Unit manager Artro)

4.4.1 Organisational structure and performance measurement

Artro's organisation is built of two parts: one part including the 15 physicians and which the CEO is responsible for, and one part including the other health care professionals such as nurses, assistant nurses and physiotherapists, which the health care manager is responsible for. The care manager's part is divided into three different units: the surgery unit, the rehabilitation unit and the reception unit. Each unit has a unit manager with a background as either nurse or physiotherapist and are also working clinically. The unit managers are responsible for organising and planning the work, developing the care operations, patient flow optimisation, and responsibility for fulfilling commitments from the buyers of the services. Recently, the unit managers has also become responsible for the budgeting:

> That is something that we have been doing the last three years… and is something that is very difficult of course, and I spend a lot of time together with our controller and we go through how we did it last year, how much will it increase (the production), it is really difficult, more of qualified guessing. […] Then we look at what factors (material, surgeries etc.) that may change during the year, and how much they cost, I am the one who decides what to include or not, and then we add it to the budget.
> (Unit manager Artro)

The unit managers see the potential in the financial measures, however, they realise that they need more education in order to run the systems on their own:

> I understand some economics, however, when we sit down (with the controller) with KPI's and the numbers spins in the Excel sheets then I realise that this is a tool that I would need to learn more about…
> (Unit manager Artro)

The CEO of Artro has emphasised that they should measure both productivity and quality results on an individual level for the physicians and the physiotherapists (the chargeable professions), which is seen as a quite controversial among especially the physicians:

> We have an open quality system and I encourage them (the physicians) to enter at least once a year to view their results, but it is a sensible question especially if you have been working here for 30 years and you see that you have bad results, it could be quite hard to understand that and instead one starts to find excuses. […] But if I see that someone has bad results then I usually recommend that person to work together with someone else for a while, since it is a problem that we are only one physician these days when we operate, it may be cost efficient but the question is if we really save money. The individual amount of production is also accessible for everyone and there is a competition between the physicians, however, it is hard to say that 15 surgeries is better than 10…
> (CEO Artro)

Being a unit manager at Artro requires ability to both manage the everyday clinical work and the financial planning and follow-up can create stress and a feeling of not being sufficient. In this case the role as unit manager can be demanding for the health care professionals to such an extent that they choose to take a step down from their financial responsibility:

> I have resigned from my position as unit manager since I am tired of being a manager. Being a manager is more of a lifestyle than a job; you are manager 24 hours a day. There is a lot that is fun but organising employees is rather difficult, especially when people are sick and the operations need to carry on. Monday morning at 05.30 a.m. you get a message that someone is sick and then you think, 'oh my god, how will this day work out'. That is why it is so important to also be clinically involved, otherwise this job would never work, it would require more staff.
> (Unit manager Artro)

4.4.2 Collaboration between controller and unit manager

Even if the unit managers are accountable for the budgeted result they have a close collaboration with the controller of Artro, with whom they have a continuous dialog, both during the monthly follow-ups but also when they meet during unofficial situations as in the coffee room. The unit managers emphasise that there is a dialog with two-way communication in which both parts learn from each other:

> When it is time for the monthly closing and one should report why the outcome looks as it does, then we have a great knowledge sharing between us, or probably she is more dependent on me in the situation when she is going to report further why this month's production is lower, e.g. several large surgeries with more material. Often one finds an explanation to why it looks as it does and she understands this […] I can comfort myself with the fact that even if I am bad at economy and constructing the budget, then you (the controller) would feel the same if you came to the surgery room, it would be really difficult, and it would be really difficult for me to take her role.
> (Unit manager Artro)

> I am with her (the unit manager) when she has meetings with her unit, then I join them and explain the financials since they are eager to understand, they are very interested in economics, and that is something that I appreciate. Last year the material consumption for surgeries increased dramatically and then we sat down and went through the reporting and tried to find explanations, it is a continuous discussion… then she explain that we have employed a new physician who is using more of a specific material when performing surgeries.
> (Controller Artro)

4.4.3 Accounting and the complexity of health care services

A background, or at least long-term experience from health care, is important for a manager when it comes to effective planning of the business, especially when the surgeries are becoming more complex:

> The controller tries to understand but she is still not involved in the business so it is hard for her. As a manager it is important to be clinically involved since this job (budgeting and planning) otherwise would be impossible. If I look at our surgery planning, we have one employee with a lot of experience and one without, and it is a big difference between them when it comes to planning efficient use of the theatres. I have my physicians in my both pockets, I know exactly how much time they need for different surgeries, and that knowledge is rather hard to mediate.
> (Unit manager Artro)

> HealthCo argues that one should utilise the theatres as much as possible, the KPI is called 'knife-time', where an optimal utilisation is 8 hours, then you only do one surgery that starts in the morning and end in the evening, then you have maximised the utilisation, however the surgery may have been conducted faster but then you lose time due to changes between surgeries, and then you only have a knife-time of three to four hours instead. This is why you need medical knowledge when you look at the numbers and work with them […] I think it can be hard for the CEO of HealthCo and his economists to interpret and judge these numbers from a distance, when they are not inside the business…
> (Physician Artro)

The fact that the complexity of health care offered has implications for designing reliable KPI's was also evident when Artro were given certain KPI's from the CEO and the CFO of HealthCo. The unit managers felt that these KPI's was not appropriate for their operations and acted thereafter:

> Earlier it was more of 'these are the KPI's you should use', said the CEO and CFO of HealthCo. All specialist business areas were supposed to use them, but they were not always relevant measures for us. Now we construct the KPI's bottom up and hence, the unit managers design the measures.
> (Controller Artro)

4.4.4 The link between input and output

The pricing of surgeries within the procurement contracts are sometimes not well linked to the actual costs, which creates frustration among the health care professionals:

> With the County Council the reimbursement level does not always correspond to the actual cost, and you cannot do calculations on everything that it should be profitable, we cannot say that we should only do these kind of surgeries since they are profitable, instead we have to look at the actual needs of the patients, sometimes the surgeries are profitable, sometimes not, it hopefully evens out in the long-run. Our problem is to change the surgeries in our business since it may not influence the economy, even if we work equally hard and do as much good; the revenues are a lottery game.
> (Physician Artro)

Health care professionals at Artro are interested in the financial outcome for each month and are eager to se the result of the work that has been put down. There are both formal meetings where the financials are reported, but those interviewed also emphasised the informal meetings that take place at the clinic, e.g. at the traditional breakfasts together with all staff each morning. However, the above mentioned unprofitable surgeries has consequences for the input-output relationship since the health care professionals have difficulties seeing the effort of their work in the financial numbers:

> We have meetings with all staff once every month where we, among other things, go through a financial report, in which we can see budgeted volumes of production, which hopefully should be mirrored in the financials. The problem is when we have a higher cost than the reimbursement, and then people feel that they work hard but that it is not reflected in the result. We could have a line-up to a certain surgery that we loose money on, when we have managed the queue the result of all work is a negative financial result, it sends strange signals and people do not understand why their effort is not mirrored in the result.
> (Physician Artro)

> Everybody (the health care professionals) is very aware of costs, which one naturally is in the private sector. Everybody wants to know and examine the production. Some month one may feel that oh my god how intense it has been, we have probably produced exceptionally much, but then we have not done it and then one needs to go back and examine what kind of surgeries we have had…
> (Unit manager Artro)

4.4.5 How to reach the budget

However, the focus on profitability and keeping in line with the budget has, even though the linkage between output and input is not always so clear, created a cost consciousness among the health care professionals in their daily work:

> Here we discuss the economy at every clinical meeting and everybody is aware of the financial situation. Here the economy is a central part of our daily life compared to larger and public health care organisations. Here the physicians are aware of that they should not waste material, they think before they insert medical pins and so on.
> (Unit manager Artro)

In order to increase production and reach the budget at the end of the year, Artro has implemented a program for profit sharing. The program falls out with a percentage of the yearly salary between one and 15 per cent, depending on if the business area reaches the budget:

> It is fun when we have to put in some effort towards the end of the year, then everybody lines up… in December we had 130 receptions on a Friday and we extended with extra surgeries in order to manage, it is everyone's choice will to put in extra effort, but many like of course to receive their bonus…
> (Unit manager Artro)

4.4.6 The founder and the business area manager

The CEO of Artro has built up the business area from scratch and is in addition a nationally recognised orthopaedic surgeon, and has also a business degree from a top tier university in Sweden. He has been working within his speciality for more than 25 years, he has developed the internal IT-system which is a combination between a journal system and a system for cost allocations. In other words the CEO of Artro is closely tied to the organisation and has a large influence on the planning, budgeting, and the daily activities:

> He (the CEO of Artro) is unique in the sense that he is both a skilled physician who can leave in the middle of a meeting when they need help with a surgery, he has a strong feeling for quality and delivers in all aspects…then he has a sense for economy, which makes everything come together. If I come up with a question, he answers in five minutes, but it is seldom that he comes to me and says 'this would I want help with'…
> (Business area manager Artro)

> Headquarters have tried to affect him (the CEO of Artro) but he is rather stable and it can blow quite a lot before something happens, nobody can touch him, he is a great factor of power in Swedish medicine and orthopaedics, that something you cannot take away from him…
> (Unit manager Artro)

CEO of Artro reports to the business area manager, who is a former management consultant with a background in consulting the health care sector. He has been working in HealthCo for a little more than half a year. The two managers have a different view on how the operations of Artro should be carried out:

> I have nothing against him personally (the business area manager), it is only that he sees it with different eyes, he comes from 'the large consultancy firm' and you notice it directly, 'you cannot perform any surgeries were you loose money, you should only do such thing that you earn money on', then you have not really understood health care. We have a mission from the County Council to take care of the patients, and then we must take care of everybody, you cannot run health care operations by choosing your patients… but he will learn as time goes on.
> (CEO Artro)

> Many physicians hang on to their Hippocratic oath, that they should always set the patient first, fine, if you set each individual patient first then we will use all single resources in order to cure one patient, then you take for granted that the resources are endless and if you do that then there will be less resources for another patient, therefore it is the physicians role to prioritise so that the resources are used effectively and efficiently.
> (Business area manager Artro)

An influencing factor in the business relationship between the two managers is that the financial reporting system of Artro, which is constructed by the CEO, is not the same system that is generally used in HealthCo. This has consequences for the transparency between the business area and the rest of HealthCo, both regarding the financial reporting and reporting of quality parameters. The financial and quality reports that the business area manager demand from Artro has to be manually prepared by Artro's controller:

> HealthCo gives us guidelines what we should report and we report in accordance to HealthCo's agenda. We have split Artro into different units, which have their own KPI's that we follow up monthly. Each have an own monthly report. However, we only report a main-unit to HealthCo and we do not report the specific units separately, as is the case within some of HealthCo's other business areas.
> (Controller Artro)

> The CEO (of Artro) has control, but it would be more powerful if there was more transparency. […] They produce a report each month where they present productivity, use of resources and the financial result. I have asked for more detailed reporting regarding quality so that I can see it and achieve transparency, which I do not have today. The CEO "feels" the quality, but that is dangerous. I need also to have access to that information, since if something goes in the wrong direction then there are incentives not to talk about it. It needs to be full transparency.
> (Business area manager Artro)

4.4.7 The founder and the unit managers

Even if the CEO of Artro has a large influence on the daily work, there may be situations were unit managers who have built their own business case together with the controller of Artro could change his decisions:

> I think that I am trying to be political correct, I try to anchor my ideas, first with the controller (of Artro) so that I have the numbers in place and then I go for the CEO (of Artro) who looks at the controller who in turn says 'yes, this is how you do it', in this way the CEO understands that the steps are already taken.
> (Unit manager Artro)

Table 8. Summary of management controls present in business area Artro

Control	How used	Implication
Organisational structure	• Organisational structure which separates physicians from the rest of the health care professionals	• Tensions between professions are hampered due to socialisation processes across professional boundaries
Budgeting	• Decentralised budgeting process • Partly limited ownership since CEO has strong influence	• Ability to affect the budget based on own values of how health care operations should be managed • Strong sense of accountability for results • Strong influence by the CEO partly hampers development of operations
Reporting	• Internal transparent and monthly reporting of financial and quality performance • Comments on financial output together with controller • Different reporting systems at use within the clinic and the HealthCo group	• Health care professionals are required to comment on the financials, which in turn push them to learn about the financial implications of health care. • Creates an interest for engaging in the financials among health care professionals
Socialisation	• Quality emphasised in registers, standards and models • Business area manager does not have full access to the financial and quality reporting • The values of the CEO and the units are shared, the employees admire the CEO • The values of the CEO and the business area manager are different	• The administrative and health care professionals are collaborating within the clinic • Lack of transparency between the clinic and the business area manager • Tensions between the CEO and the business area manager • A decoupling exist between CEO of Artro and the rest of HealthCo group
Recruitment and Promotion	• Recruitment and promotion of individuals that has experience from e.g. financial reporting	• Staff that are more experienced with working with financials can act as ambassadors for hybridisation within the organisation
Networks and Meetings	• Follow-up meetings • Clinical meetings each month with financial presentation • Daily informal meetings such as the daily breakfast	• Knowledge sharing between professions • Creates a common culture and a belonging to the Artro organisation • Lowers barriers between professions • Emphasis the importance of all professions

5. Analysis

The empirical study has examined the use of control within three different business areas in HealthCo. The control framework of Alvesson and Kärreman (2004) has been used to identify technocratic and socio-ideological controls in the empirical data. In accordance with Alvesson and Kärreman's (2004) view, different controls has not been classified as either technocratic or socio-ideological, but instead studied from both a technocratic and socio-ideological perspective in the summary tables ending each empirical description. This approach is according to Alvesson and Kärreman (2004), required in order to identify the interplay between controls i.e. the interfaces of controls. This perspective results in that the controls identified in the summary table has both a socio-ideological and technocratic dimension. For example; budgeting can both be seen as a technocratic control for planning as well as a socio-ideological tool for creating a sense of commitment. The study has also examined the hybridisation process in the business areas and in different professional groups in HealthCo. The management controls identified will serve as a foundation for an initial analysis of how these controls and the interfaces of these affect the process of hybridisation. The analysis will be followed by a discussion, focusing on the implications of the findings and how they add to the understanding of the hybridisation process. The discussion is intended to conceptualise the findings and present how the present study adds to current knowledge.

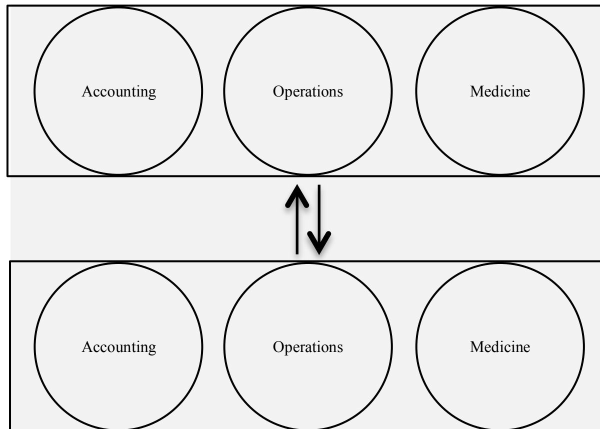
Table 9. gives a summary of the controls that were found based on empirical data and summarises the empirical description of each business area. This table is the basis for the analysis of how management controls and its interfaces affect the hybridisation process.

Table 9. Summary of management controls present in HealthCo

Control	Primary Care	Geriatric	Artro
Organisational structure	• Medical, operational and financial roles on each organisational level which implies that operational managers gets both medical and financial support • Lowers barriers between professions	• Shared-leadership structure • A two parted organisation structure which results in high barriers between physicians and remaining professions	• Two parted organisation structure • Socialisation processes across professional boundaries unify professional groups
Budgeting	• Decentralised budgeting process • Strong sense of ownership of budget and ability to affect budget based on own values of how health care operations should be managed	• Partly decentralised budgeting process mainly performed by the head unit nurse and only for selected cost items. • Creates a low involvement and commitment from physicians	• Decentralised budgeting process, which is partly defined by the CEO who has strong influence. • Budget based on own values of how health care operations should be managed
Reporting	• Transparent reporting of performance in relation to budget and county council quality parameters • Requirement to write comments on financial output which implies training in understanding the financial implications of health care operations	• Only partly transparent, reporting system, in which the Head unit nurses are followed up on staff expenditure and medical responsible physicians are followed up on production • Head unit nurses have a tighter connection to the financial work in comparison to the medical responsible physician.	• Transparent internal reporting system that differs from the general HelthCo system and is therefore not externally transparent • Requirement to write comments on financial output which implies training in understanding the financial implications of health care operations
Socialisation	• Quality is emphasised in standards and models • Quality is considered superior to cost which implies that the values of health care professionals are supported, which in turn results in their acceptance of technocratic controls	• Quality emphasised in standards and models • Split socialisation process in accordance with a two-parted organisation structure.	• Quality emphasised in registers, standards and models • The CEO is a key person in the socialisation process internally, however the values of the CEO and the business area manager differ which results in a decoupling
Recruitment and Promotion	• Recruitment and promotion of individuals that has experience from e.g. financial reporting which implies that they can act as ambassadors for hybridisation within the organisation	• Recruitment and promotion of individuals that has experience from e.g. financial reporting which implies that they can act as internal ambassadors for hybridisation within the organisation	• Recruitment and promotion of individuals that has experience from e.g. financial reporting which implies that they can act as internal ambassadors for hybridisation within the organisation
Training	• Leadership training which creates a sense of being recognised and invested in and creates openness to technocratic controls	N/A	N/A
Networks and Meetings	• Training and meetings that enable knowledge sharing and creates a common culture as well as lowers barriers between professions	• Meetings and procurement project which enable knowledge sharing between professions and attempts to lower barriers between professions	• Meetings, which enable knowledge sharing and creates a common culture internally as well as lowers barriers between professions

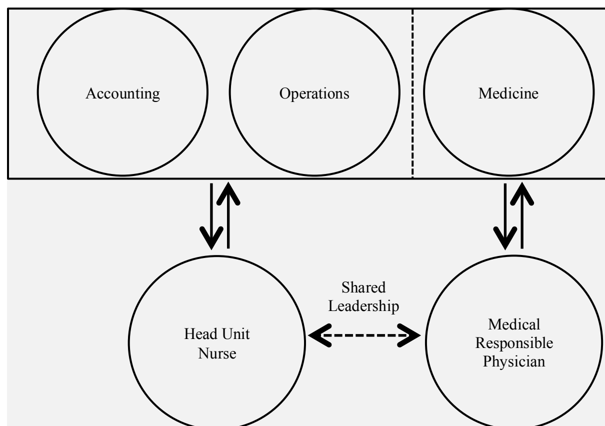
5.1 Organisational structure

Figure 3. Professional interdependence, Primary Care



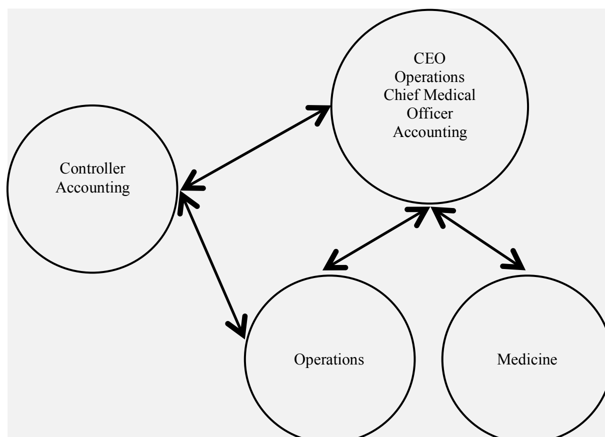
The figure illustrates the professional interdependence in business area Primary Care with three distinct roles on each hierarchical level.

Figure 4. Professional interdependence, Geriatric



The figure illustrates the professional interdependence in business area Geriatric with shared leadership and a dual organisational structure.

Figure 5. Professional interdependence, Artro



The figure illustrates the professional interdependence in business area Artro, where the controller acts as a support for both the CEO and the unit managers. However not for the physicians since they lack financial responsibility.

The organisational structure as described in the empirical data, appears to have a strong influence on the interdependence between professions. The three figures to the left, illustrate this interdependence, within each business area, which will be further discussed in this section.

The close cooperation between the administrative professionals and the health care professionals in the controller and unit manager relationship in business area Primary Care (see Fig. 3), enables the barriers between the two professions to be lowered and that a mutual understanding with a common language can emerge between the two groups. This reinforced relationship has contributed to a better understanding between the administrative professionals and the health care professionals and results in a merger between the two cultures of the professions involved. The 'new' culture that develops is based on the cornerstones of patient safety and quality delivered in a productive and resource efficient way with the aim of both treating as many patients as possible (the goals of the health care professionals) and at the same time generating return on invested capital (the goal of the owners).

The CFO of business area Primary Care, admit that the only way to be accepted by the health care professionals is to continuously listen and try to understand their situation. After all the health care professionals are experts with an academic background and they need to be treated accordingly. At the same time, as the unit managers have entered into the hybridisation process, the administrative staff has 'transformed' in connection to the hybridisation process. This transformation process started when the administrative staff got closer involved with the health care organisation, achieved knowledge about medical practises and processes in order to create a common 'language'; a language that mixes accounting with

medical practice. This language is a cornerstone in the hybridisation process and clarifies for the staff the linkage between health care and financial measures; in other words the linkage between the health care professionals socio-ideological, or ethical, agenda and the technocratic controls. In the case with HealthCo, controllers in the organisation who view themselves as 'supporters' to the health care professionals. In this sense, they have emerged from being a 'profession' to becoming 'supporters' with the mission to teach and explain accounting techniques to the health care professionals. Therefore, in this case accounting is viewed as 'tools' rather than 'abstract knowledge', as discussed by Kurunmäki (2004) when analysing professional associations in the Finish medical society.

It must be emphasised that the organisational structure within the business area Primary care, which is illustrated above (see Fig. 3), is distinctively different from those organisational structures that are portrayed in other studies of health care organisations (see e.g. Kurunmäki et al., 2003). Accountants have traditionally been working at management level in health care organisations and are usually not personally connected as a support function to each organisational level. Another observation is that hybridisation, as described in previous studies, is performed by the health care professionals of their own free will (although external pressures may exist) and not with the support and push for change from controllers.

In the Geriatric area (see Fig. 4), the organisation is structured into two distinct groups; the physicians on one side and other health care professionals such as nurses and assistant nurses on the other side. This organisational structure is traditional in the sense that accounting is a management function of the organisation. While accounting permeate into the practices of the head unit nurses and those that are subordinated, physicians are resistant to take part of this development. Even though the leadership of the unit is formally shared between the head unit nurse and the Medical Responsible Physician, it is evident that each leader is head of their respective professional group. As the physicians are seen as superior to the nurses and other healthcare professionals, the head unit nurses have a continuous struggle to make their accounting tools in the unit operational. Although these two groups are formally working closely together, treating the same patients etc. informal barriers keep them distinctively separated from each other. While the head unit nurse is hybridised and coupled to the management team, the medical responsible physicians are decoupled from the management team resisting hybridisation.

The introduction of a new organisational structure, imply an attempt to break the cohesiveness of the old structure. This is however seen by the physicians as a threat to their medical autonomy. Since the physicians are of the opinion that they lose power and authority, this frightens them since they feel that their hierarchical position in the organisation is challenged. This observation is in line with previous studies, which have found that health care organisations protect their formal structures from evaluation since attempts to increase efficiency may undermine the so-called *ceremonial conformity* of the organisation, and in turn impair the support of the organisation, and its legitimacy (Meyer and Scott, 1992). At the same time, the Chief Medical Officer who is responsible for the change is convinced that the physicians will benefit from a new organisational structure and provide them with shorter communication lines, which in turn will enable them to treat patients more efficiently. In other words, the Chief Medical Officer underpins the technocratic change with the argument that it will be in line with the socio-ideological values of the physicians. However, since the process of breaking structures and habits moves slowly, the physicians start to question if a change in technocratic direction really is beneficial for the quality of the work. In other words they cannot see the linkage between their socio-ideological values and the technocratic

change. The resulting suspiciousness towards the change process makes it take even longer time, with even more anxiety among the physicians as a result.

The organisational structure in business area Artro (see Fig. 5) is similar to the organisational structure in business area Geriatric in that it is by tradition structured around professions rather than units. However, it must be emphasised that in contrast to the Geriatric, all health care professionals at a management level in Artro have entered into the hybridisation process and work closely together with the administrative professionals. Since the CEO of Artro is both a well renowned physician and holds an accounting degree, he speaks the same socio-ideological language as the health care professionals and has managed to convey to the health care professionals how accounting techniques may be used as a tool for improving health care. The controller works as a support, both for the CEO, and for the head unit nurse with subordinated managers supporting with budgeting and reporting. In line with the Primary Care area, the controller has a central role in both pushing for technocratic control and for supporting and educating the health care professionals. Similarly to the Primary Care area, the controller is getting insights in health care in communication with the head unit nurses. Through their collaboration accounting techniques are smoothly introduced in the area.

In general, it may be concluded that the organisational structure with a controller tied to each unit manager efficiently supports the managers when it comes to financial planning, follow-up and decision-making. When it comes to hybridisation, this set-up pushes the unit managers to learn about the financial reporting since the controller is continuously questioning the financial outcome. At the same time, the close relationship between the unit manager and the controller provides confidence for both parties. The health care professionals feel that they have support when entering new territories, when hybridising from the medical profession into the profession of accounting. The relationship also provides confidence for the controllers in that they get a more thorough understanding of the health care operations and in this way better can contribute to the operations by assisting the health care professionals to develop and implement more adequate financial reporting.

5.2 Budgeting

In HealthCo, budgeting is used as a technocratic control for forecasting production, allocating resources and setting the productivity for the year. However, budgeting also represents a mechanism of socio-ideological control, signalling that the person who establishes the budget is the person who best knows how the business should be operated. In addition, it makes the person feel responsible for the budget throughout the year. The prerequisite is that the person responsible for the budget is given the tools and authority to affect the business in accordance with the budget. In business area Primary Care, the unit managers are alone responsible and accountable for the budget. This results in that the unit managers are free to determine the outcome of their business based on their own values and ideas of how high quality health care should be created. Further, the empirical data suggests that it is vital for the accountability of the unit manager that there is a clear linkage between the input and output measures in the design of the budget and it has consequences for how the unit manager allocates resources in order to both deliver a high quality care with optimising use of resources. By experimenting with resource allocation, the manager can learn how to achieve an efficient use of resources without violating ethical perspectives. In the words of the CFO of Primary Care; “through budgeting you can show your stakeholders what you want to do with your business, as well as being a pedagogic tool for expressing directions”.

In accordance with Alvesson and Kärreman (2004), technocratic control in relation to budgeting is based on the “thinking’s, feelings and identity formation” of the Primary Care

unit. The interface of technocratic and socio-ideological control originating from the decentralisation of responsibility to the unit manager is one factor that in combination with others facilitates the hybridisation process. The fact that the unit managers both have a financial responsibility and a responsibility for the health care operations facilitates the willingness to take on financial responsibilities. The alternative would be to only focus on financial responsibility, and leaving the medical career, a choice that is often not seen as an alternative for the health care professionals. This finding is in accordance with Jacobs (2005). The linkage between costing and caring is also facilitated by the fact that unit managers are allowed to invest part of the profit, for example in new equipment, that increases the quality and patient satisfaction (Llewellyn, 1998).

In the Geriatric clinic, the budget is partly decentralised, as the head unit nurses and the Medical Responsible Physician only are responsible for the budgeting part of the costs, without being given full responsibility for the income statements. Instead, the hospital management decides on several cost items and production. Management control is carried out at the administrative level of the organisation, whiles in particular the Medical Responsible Physicians cannot influence the technocratic controls. Since the unit management are not given full control over the financial situation they are dependent on the administrative professionals. In addition, the fact that the unit management is not entrusted to take part of the income statements of the unit makes it difficult for them to see the links between input and output, which enhances passivity. In comparison to the Primary Care units, the passivity that is present in the Geriatric's units result in a much lower sense of accountability among managers. Physicians, who feel that their work and role is not understood, tend to develop a 'complaining culture' as a response to management's initiative to increase efficiency. The health care professionals, and physicians in particular, view costing and caring as counteracting rather than aligned to each other in contrast to the Primary Care units (Llewellyn, 1998).

In the business area Artro, there is a decentralised budget process similar to the one within business area Primary Care. The process generates accountability among the unit managers even if they are not entirely free to set the budget. In the business area there exists an informal hierarchy in which some parts of the budget process are separately managed by the CEO, e.g. salaries. Although this creates frustration among some unit managers, there are no signs of deteriorated accountability within the business area.

5.3 Reporting

Reporting is a second control form, which serve as an important technocratic control tool in the three business areas studied. The scope of this technocratic control and how it is tied to socio-ideological control within each business area will be discussed below.

At business area Primary Care, unit managers are hybridised in the sense that they use financial reporting as a tool for follow-up and evaluation of their business. It appears that the unit managers have adapted to certain norms of the administrative professionals in the sense that they accept and understand that it is important to have the financial measures in place in order to evaluate, understand and develop the operations of their Primary Care units. The linkage between the technocratic controls and the values of the health care professionals is enhanced by the fact that if the unit makes a positive result, part of this result will be invested to improve the work of the unit, and part will fall out as bonuses to the health care professionals. Thus, in order to be able to plan for future investments, the unit managers need to have the financial issues under control to evaluate if there could be space for any future investments. The second way of creating compliance between delivering high quality care and

the financial reporting system is the fact that no bonus is paid on financial performance if the County Councils quality parameters are not met. This signals that the customer (the County Council is the customer) quality criteria are superior to financial performance, which in turn is in line with the work ethics of the health care professionals.

The finding is in accordance with Llewellyn (1998) who says that breaking down the boundaries between costing and caring can enhance hybridisation by showing how costing and caring are similar and how costing may support rather than jeopardise caring. In the Primary Care unit, the values of both the administrative professionals and the health care professionals merge into one socio-ideological control in the sense that the unit manager understand that it is important to have the financial measures under control in order to be able to deliver safe and qualitative health care.

Primary Care's "pay-for-service" agreement with the County Council creates a linkage between effort being put down and the financial outcome reported in the monthly follow-up. This link between input and output is stronger in Primary Care compared to both Geriatric and Artro. In Primary Care, the technocratic control reflects reality better and the health care professionals have a higher confidence in the financial result since they can see the results of their efforts.

Involvement in this type of technocratic control is pushed and enhanced as a result of that unit managers are required to give monthly comments on their results. This requirement forces them into exploring and learning about the financial consequences of their operations and reinforces their commitment to this type of technocratic output measures. Some unit managers commented that they needed more education in order to write proper comments with more depth, which indicates a willingness to become more acquainted with the financial reporting and thus, even more hybridised. This development is as well reinforced by the fact that some unit managers communicate their financial and quality outcomes to their subordinates. This monthly routine has sparked the interest among some of the health care professionals, which in turn has lead them to start asking questions about the financial outcome. This drives hybridisation in the sense that the unit manager needs to have an even higher understanding of the financials in order to answer the questions and explain the outcome in a trustworthy way. The financial transparency from group level to individual physician in Primary Care has two important implications from a control perspective. First, the transparency makes it easy to track and adjust deviations from the budget. Second, there is a "dual" transparency in which health care professionals can track down how much profit their unit is generating. When the health care professionals realise that only a minor profit (for some units a negative result) is generated, they feel confident that they work for a credible company that do not create huge profits on the expense of quality and ethical values. Through the dual transparency mechanism they can ensure that HealthCo does not violate their basic values of how qualitative care should be managed and delivered. Hence, the organisational transparency that accounting achieves, and which usually is used by top management to control the organisation, is in this particular case turned the other way around and used by the health care professionals to control the administrative professionals (Hopwood, 1983). The transparency is also important when there is risk for the health care professionals being accused for working in a private health care company that emphasise profits before quality. If such a situation occurs, the transparency and the health care professionals financial knowledge can be used to illustrate the actual situation.

To summarise, the construction of financial and quality reporting in the Primary Care area creates clear incentives for the unit managers to learn and explore output controls by own motivation, rather than of pressure from the administrative profession as observed by several studies (see e.g. Kurunmäki et al., 2003).

In conformity with the budget in Geriatric, the financial reporting in this business area does not include an income statement but instead KPI's that are determined by top management. The management has tried to simplify the complex reimbursement system by communicating production in terms of patients instead of DRG-points. In comparison to business area Primary Care, this reporting structure lacks a mechanism for illustrating the link between costing and caring (Llewellyn, 1998). This reporting structure in comparison to the alternative of not having a performance measurement system, may guide the health care professionals to engage with the numbers (Kurunmäki and Miller, 2006). However, the reporting structure lacks clear incentives for the health care professionals to engage by free will, which is a consequence of that they lack full accountability for the results since they are not entrusted to see the income statements. This is remarkably different compared to the business area Primary Care. The question arises why the head unit nurses do engage in efforts to measure and enhance efficiency. Reflecting upon Blomgren's (2003) study, one possible explanation may be that the head unit nurses has managed to strengthen their professional position in relation to the physicians as a result of undertaking financial responsibility. In interviews, medical responsible physicians working in the Geriatric business area confirmed this explanation.

Previous studies (see e.g. Kurunmäki et al., 2003; Pettersen, 1999) have observed a resistance to financial reporting and measurement. This resistance is also prevailing in HealthCo and the CFO of HealthCo emphasises that it has been hard to change the mind-set of the health care professionals to have a more positive attitude towards measurement. There is also evidence of this resistance in the empirical data in which the monthly reporting and the attempt to increase transparency within the Geriatric have worried the physicians who are afraid of being measured, especially on an individual basis. The physicians in the unit strive for autonomy and believe that one should never question the their work with the motivation that a physician always does what is seen as best for the patient. There is also a culture of suspicion towards financial numbers that underpins the general opinion among physicians that working with numbers are not part of their work. The attitude is that numbers originate from the harsh and calculative economic world, far away from the ethical values guiding good medical care and that the quality of human life cannot be valued in monetary terms. This opinion of the doctors contradicts with the general idea of technocratic control, which emphasises detailed measurement and transparency. There is also a contradiction between the ambition of the top management in HealthCo to measure as much as possible and the opinion of physicians that care should not be measured in financial terms. The fear of transparency results in a decoupling between the physicians and the administrative professionals. Several reports confirm this finding that technical activities and demands for efficiency create conflicts and inconsistencies in an institutionalised organisation's efforts to conform the ceremonial rules of production (Meyer and Scott, 1992, p. 37).

At Artro, the unit manager expresses resignation over being accountable for the monthly financial outcome due to a weak linkage between the effort that is being put down by the health care professionals and the financial outcome. The weak linkage is an outcome of the purchaser-provider model where the County Councils reimbursement level for certain surgeries is below the actual cost. The result is a technocratic control that does not really

reflect the reality at the surgical unit and the weak linkage causes the health care professionals to stop believing in the technocratic control since they are unable to properly influence the financial result, making it hard to understand the input-output relationship. When the linkage between output and input is weak, they tend to control their actions in accordance with their socio-ideological controls on how care should be managed and delivered, without linking these actions to the outcome of the technocratic controls. This results in a weak link between costing and caring (Llewellyn, 1998) and thus, between technocratic and socio-ideological control.

The transparency between Artro and the business area manager is limited due to an incomplete interface between the reporting systems at Artro and in the HealthCo group. The lack of "automatic" transparency in the reporting system results in a need for a "manual" transparency in the sense that the controller of Artro manually reports the financial results for the clinic to the business area manager. Since the business area manager does not have full access to the financial results from different units within Artro, he is in a way denied access to the organisation. The reduced transparency favours the central position of the CEO of Artro, who has the power to control what is shown and what is not shown in the financial reporting. In this aspect, the technocratic control does not work properly since the clinic lacks the transparency that HealthCo strives for. This situation is the result of a conflict between two different socio-ideological controls: the CEO of Artro emphasising top quality care with the latest medical methods and the business area manager who emphasise that they should only perform services that generates profit. Thus, the communication between the two managers is not based on the same socio-ideological values. In addition, they work with two different technocratic systems: one constructed by the CEO of Artro, used within the organisation, and the other being the general system in the HealthCo group. Two socio-ideological controls and two technocratic systems result in a decoupling between Artro and HealthCo as a whole. This finding is in line with Scott and Meyer (1994) who highlight that there may be advantages of decoupling when people are trying to protect a certain order in a conflicting and inconsistent environment. The fact that the technocratic system within Artro is only fully visible internally works as a shield from external attempts to control their part of the organisation. It must be emphasised, however, that the technocratic system within Artro is well embedded in the health care practices and that the managers within this area could all be seen as hybridised.

It is observed in the empirical data that the CFO in business area Primary Care and the controller in business area Geriatric have developed an accounting-medical language that they use when they discuss and evaluate monthly financial reporting together with the health care professionals. Pure accounting terms such as EBITDA and operating capital needs to be reformulated and explained through a medical point of view in order for the health care professionals to understand. Hence, the accounting-medical language provides support for the health care professionals and becomes a crucial component of the hybridisation process.

5.3.1 Change-management and pressure

Another question that these observations bring about is how the systems of financial reporting have been implemented into the technical core of health care practices and if the manner of implementation has affected the acceptance by the health care professionals and thus, their hybridisation. Kurunmäki et al. (2003) emphasise that a slow and stepwise implementation rather than a forced implementation facilitates hybridisation. Moving too fast may have the consequence that the administrative professionals continue their process of developing the technocratic controls while the health care professionals continue their operational activities and thus a decoupling between the two professions continues. The CFO of HealthCo emphasise a step-by-step approach, and stresses that attention has to be paid to that health

care professionals may need to take their time when it comes to changing the mind-set. This has been the case in the Primary Care area in which administrative professionals have "pushed" for a change of mind-set. They emphasise a steady approach in which the implications of the technocratic system and the financial reporting has been discussed thoroughly. The result has been acceptance by the health care professionals in the business area to approach the financial measures and the monthly reporting.

In the Geriatric area, however, management has taken another approach to implementation, being hesitant to push for technocratic control. They have feared being on a collision course with the values of the health care professionals if focusing too much on profitability and profit. This in turn has resulted in the administrative professionals not being able to explain and discuss the reasons behind the technocratic controls, and therefore not been able to illustrate the linkage between the technocratic controls and the socio-ideological values. They have not managed to explain that a higher profitability will lead to more money being invested in the health caring activities, which will increase the quality for the patients. This argumentation is used to support hybridisation in the Primary Care area, in which profits are seen as something positive and through reinvestment strengthening the business. Instead, the opinion of the administrative professionals in Geriatric has resulted in a slow and unclear process of change, in which objectives and benefits have been perceived as rather vague. The result is that involved physicians get anxious about change, which in turn results in a decoupling between the physicians and the administrative profession and also a resistance to become hybridised. Hence, in addition to the findings of Kurunmäki et al. (2003), it should be emphasised that a change-process may also be too slow, especially in those cases in which management does not have the courage to challenge the existing organisational structures and values. This, in turn, may hinder the hybridisation of the health care professionals.

There is evidence in the empirics to suggest that there is a linkage between the process of change-management and the degree of pressure, either internal or external. If the pressure is relatively high, the process is significantly shortened.

There has been a financial pressure in business area Primary Care to deliver positive financial results due to historically low performance. The health care professionals are to a large extent aware of that a negative result may impact the quality delivered to patients or even result in a closedown of the unit. Several interviewees mention the fact that it is even more important to deliver positive results due to the private ownership of HealthCo, and that the owners demand return on their invested capital. This financial pressure to deliver positive results have been mirrored in the mind-set among the health care professionals, who believe that financial control, follow-up and interpretation of financial results on a monthly basis is crucial for long-term survival. In this case, the financial pressure to deliver positive financial results have been a driving factor behind the hybridisation of the health care professionals at the Primary Care unit. The importance of pressure to achieve health care professionals acceptance to change, is in line with what is concluded by Kurunmäki et al. (2003) and Llewellyn (1998). Further, the mind-set that financial reporting is an important part in order to keep the daily operations under control is spread further beyond the unit managers, and to the rest of the health care personnel. Even if they are not actively working with the numbers they show an interest for understanding and improving the financial result, since they are also aware of the consequences that may follow poor financial performance.

At business area Geriatric, the Healthcare choice reform that was implemented for the ASIH-unit, was used as an external argument by management for "pushing" for increased

measurement at an individual level and thus, emphasising transparency. The relatively low financial performance of the ASIH-unit enabled management to use increased transparency as a requirement for not closing down this part of the business. The pressure to change the practices was, at least partly, enough in order to convince the physicians to start measuring patient visits per physician and day. Management may also use the socio-ideological values of the health care professionals in order to implement more technocratic controls and thus initiate hybridisation. At the Geriatric unit, bedsores and infections violated the values of good care and motivated the staff to improve practises. Another pressure comes from outside of the organisation not meeting quality parameters of the customer (the County Councils) and the risk of bad reputation. In this case, the poor results were used in order to question the actual processes and procedures and emphasise the need for measurement, followed-up and improvement. The administrative professionals challenged the values of the unit management by questioning them if they really wanted their unit to have such poor results. By questioning if they really were operating in accordance with the general ethic values in the health care sector, the administrative professionals could influence the medical staff to implement output measures and construct procedures for how to tackle the problems. In other words, management pushed for an increased use of technocratic controls based on the health care professionals' own socio-ideological values.

As mentioned above, Kurunmäki et al. (2003) argue that although a pressure exists, a slow implementation facilitates hybridisation. However, the findings of the present study suggest that the appropriate manner of implementation is also contingent on the intensity of the pressures. As discussed above, a too slow implementation may lead to resistance towards change. This calls for a broader perspective when it comes to understanding the implementation of technocratic controls, and thus the base for hybridisation. Given the three cases above: the Geriatric unit with slow implementation facing resistance from the physicians, the Primary Care unit with financial pressure and a fast implementation in which acceptance is reached among the health care professionals, and the ASIH-unit at the Geriatric with qualitative pressure and fast implementation, the following may be concluded. In those cases when the pressure is low, i.e. there is no Healthcare choice reform foreseen, the profitability is low or there are quality related issues, it is important to manage the change-process in a way that pays attention to the opinions of the health care professionals. The process is characterised by a need of mutual trust building between the administrative professionals and the health care staff. Management needs to thoroughly describe the linkage between costing and caring (Llewellyn, 1998) and thus merging the technocratic controls and the values of the administrative professionals with the values of the health care professionals during a longer period of time. However, a too long implementation phase may lead to further resistance. On the other hand, in those cases where the pressure is high, the implementation process may be shortened since it is less room for questioning and obstruction from the health care professionals, and they tend to become hybridised faster and with less resistance.

In some cases the socio-ideological values of the health care professionals are changed as a consequence of pressure from technocratic controls. However, these situations are only observed in the present study as a consequence of external factors acting as technocratic controls. This is the case when the health care professionals are instructed to follow the recommendations from the County Council regarding what drugs they can prescribe. The recommended drugs are cheaper but at the same time they may have more negative side effects. In this case the recommendations, which are technocratic controls, overrule the socio-ideological values of the health care professionals, who admit that they want to prescribe the highest quality possible but that they do not do it since they need to follow the

recommendations. In these cases, the County Councils opinion about what is to be prescribed as good quality can work as a substitute for how the health care professionals normally describe quality in accordance with their own ideas. The health care professionals have great faith to the County Councils recommendations, and they are willing to follow these, even if they admit that they are not always optimal. Hence, they are controlled by a technocratic control but at the same time, this control is not based on their own socio-ideological values of quality, instead it is based on the County Councils description of quality. In other words, the technocratic control from the county council impacts and changes the mind-set of the health care professionals regarding what is to be seen as an appropriate description of quality in health care. This is in line with Alvesson and Kärreman's (2004) conclusion that the technocratic controls may affect and form the socio-ideological controls among the employees. However, one may question if the health care professionals would have been willing to prescribe less quality drugs if the recommendations came from HealthCo? The answer is probably no, since the health care professionals are careful to point out that they would not work for a company that did not strive for always delivering the highest quality possible.

5.4 Socialisation

It is emphasised in prior research that socialisation processes are vital in gaining the employees' acceptance to technocratic and bureaucratic forms of control (Abernethy and Stoelwinder, 1995). In the Primary Care area, empirical data reveal several attempts to internalise the health care professionals into the use of technocratic controls by recognising the values and ideas of the health care professionals. The business area manager adjusts to the socio-ideological ideals of the health care professionals in different ways. By speaking the same medical language as the employees and also emphasising the importance of taking the employees' opinions into consideration, she creates a sense of trust among them and they identify themselves with her values and her management style. Her way of being, acting and communicating creates a sense of security among the staff and they open up for communication. Since there is a mutual trust between the business area manager and the employees, both parties are committed to follow directions and decisions. Sharing the same ideas for how health care should be organised and carried out, the health care professionals accept, and see the value of the hybridisation process. This finding is in line with Abernethy and Stoelwinder (1995), regarding the conflict between medical professional values and values introduced by the increased use of control. Through the socialisation process, the business area manager creates acceptance for technocratic forms of control; not by threatening the values and objectives of health care professionals, but through giving examples of how control can be used as a tool to strengthen socio-ideological values and practises in health care.

The HealthCo-model can also be seen as part of the socialisation process, as the values described in the model are in line with the health care professionals' ideas and thus give them an opportunity to identify themselves with the organisation rather than the profession. This socialisation process is facilitated by the emphasis of the management that profitability is achieved through investment in modern medical techniques, rather than cost savings. However, it must be emphasised that it is unclear how much impact the relatively distant company vision and model has on each individual employee in HealthCo. It is rather through the socialisation process described in business area Primary Care, in which managers use the vision in their communication with subordinates, that the vision is conveyed to the health care professionals. This is also demonstrated when the CEO of HealthCo travels to the Geriatric unit in order to question the quality in comparison to the financial result. When emphasising

the importance of keeping quality central in HealthCo's operations, the CEO of HealthCo portrays the vision and enhances its impact at lower organisational levels. Management signals that the organisation stands for the same values as the health care professionals, which in turn results in a more positive view of the technocratic controls, and the health care professionals understand that these are implemented in order to deliver both a high quality and a financial return.

In the Geriatric area, there are signs of socialisation when the CEO of the Geriatric unit involves the health care professionals when writing a new tender. This is an attempt to involve the health care professionals in integrating costing and caring. This involvement opens up for communication between the administrative professionals and the health care professionals and sparks a learning process between them.

In business area Artro, it appears that the CEO takes lead in the socialisation process, demonstrating that it is possible to work both actively as a physician performing high quality surgeries and at the same time develop and implement technocratic systems of control. Since the CEO works clinically in teams with the health care professionals, and thus being both a health care professional and an administrative professional, nobody of the interviewees questions if he understands the operations of the business. Since the health care professionals know that the CEO is a knowledgeable person who prioritises quality and provision of care to all patients prior to profitability, it is easier for them to believe in the technocratic controls and implement them into the business. Hence, since the health care professionals are aware that they share the same socio-ideological values as the CEO, they are not afraid of using the technocratic controls in their daily work, and thus, become hybridised.

The health care professionals are as a group strong in their values to such an extent that they quit their jobs if there is a too large difference between their own values of putting the individual patient first and the organisational values. At the Primary Care unit the unit manager admits that she would quit her job immediately if the organisation drifted away from the core values of always prioritising patient safety first, followed by quality, working atmosphere and then productivity and financial results. This strong socio-ideological control has a strong impact on the technocratic controls in the manner that the unit manager would never implement, follow or refine the work according to the financial measures if it would not primarily benefit the patient and secondarily the working atmosphere for her fellow colleagues. In this case, hybridisation will only occur if the unit manager is certain that the use of the financial tools will benefit her own values of how health care should be organised and provided. If the unit manager is not certain, this will either lead to a specific decoupling from the technocratic control in question or, if the values are suppressed, that she quits her job immediately. It is likely that this fear of working for an organisation not providing the right quality not only originates from the professionals values, but also from the society debate regarding quality scandals in private health care.

5.5 Recruitment and Promotional activities

Recruitment represents a possibility for the organisation to select members based on their education, previous experiences and attitudes, in order to shape the socio-ideological landscape of the workforce (Hopwood, 1974). When studying the background of the administrative professionals, the majority of them have previous experiences from the health care sector. At the same time many of the health care professionals in HealthCo have a background from running their own health care businesses or experiences from having worked in privately owned health care companies before. Interviewees mentioned that they already had an interest for taking on a financial responsibility and also an understanding for

the linkage between patient care and financial impact when they entered HealthCo. These employees can take on the role as ambassadors for explaining the relationship between costing and caring and thus facilitate the hybridisation process for other health care professionals within HealthCo. Likewise, since the administrative professionals have previous experience from health care, they are most likely aware of the challenges of introducing technocratic controls in a health care organisation. The importance of recruitment in the hybridisation process is emphasised by Llewellyn (1998) who found that new managers on key positions in the organisation was crucial in order to disrupt the inherent cohesiveness and open up for a new attitude in order to facilitate hybridisation. There are many examples of that HealthCo have strived for recruiting new managers to key positions, one example being the recruitment of the CEO of HealthCo, who challenged old structures in Primary Care, reorganised the business area and opened up for a new attitude towards technocratic forms of control.

It is not only recruitment that facilitates the hybridisation process; promotion of employees may be an alternative. There is evidence to suggest that some of the employees who succeed in breaking down boundaries between costing and caring also are promoted to managerial positions within the company. In addition it is not only the health care professionals that are promoted towards more administrative roles. There are also examples of the other way around, when the administrative professionals engagement into health care practices can be rewarded through promotion. This occurred in business area Primary Care when a former marketing director was promoted to the role as unit manager for one of the units.

Nevertheless, recruitment may also have an opposite effect, discouraging hybridisation or even resulting in an organisational decoupling. Artro is an example of such a situation where the newly appointed business area manager has not managed to gain trust from the CEO of Artro. Decoupling occurs since the two managers do not share the same socio-ideological values, which results in that they communicate from two different standpoints.

5.6 Training

Training as a tool for internalisation is emphasised in previous literature. Abernethy and Stoelwinder (1995) argue that in conformity with socialisation, training may create acceptance to technocratic forms of control. Since health care professionals generally are more loyal to their profession rather than the organisation itself (Abernethy and Stoelwinder, 1995), efforts to create alignment around organisational values becomes particularly important.

The training provided in business area Primary Care contributes to such an organisational alignment. The leadership course gave health care professionals the opportunity to reflect upon questions on how to align costing and caring. The fact that the leadership training includes examples of leadership implications from other business sectors equalises the leadership in HealthCo with leadership in organisations outside the health care sector. This signals that the unit managers are managers in a profit making company, and thus, that they are an important part of developing the business of this company. The message was reinforced when the teacher talked about the responsibilities to quality and financials tied to the managerial role in general. The ‘heart and brain’ metaphor used in the training session highlighted the challenges of combining the health care professional role with the managerial role including financial responsibility. The unit managers at the leadership course were fast to admit that the socio-ideological controls and the ‘heart’ perspective are the guiding controls in their daily decision-making. However, it was clear that some of the participants were more

used to technocratic controls and a 'brain' perspective in their leadership, and pointed out that these controls were necessary in a health care company such as HealthCo. In the discussion that followed, those who were more positive questioned the participants who were more reluctant to talk about the 'brain' perspective and technocratic controls. They were asked if they really were capable of being managers without equally emphasising both the 'brain' and the 'heart' perspectives. In the following discussion the participants who were more positive to technocratic forms of control explained how their technocratic decision-making was based on their socio-ideological values. For those who were more pessimistic about the technocratic controls, this made the linkage between costing and caring, and thus technocratic control and socio-ideological control, somewhat clearer. Some of the participants realised that they could, and probably already used, the 'brain' perspective without loosing the 'heart' perspective. However, it was emphasised that you should not forget your origin as a health care professional and become too much of a 'manager' in a privately owned company. The leadership course cleared out the prerequisites for the hybridisation process in the sense that the more pessimistic unit managers were shown how to become hybridised without loosing your core values as a health care professional. More importantly, the more pessimistic managers understood that they were probably already using the 'brain' perspective in their daily work; they were just not able to see the linkage between the technocratic and the socio-ideological controls.

In addition, the fact that business area Primary Care invests in a leadership course is a sign that the unit managers are recognised as important members of the organisation. This training can be seen as part of the organisational structure and an incentive to engage in technocratic forms of control in line with Jacobs (2005). There is evidence that this training is an attractive reward for the health care professional that has been successful in the business area and thus, has been promoted to a managerial position. In such a sense, the course can be seen as an incentive to hybridise. The absence of a similar training in the two other business areas is probably one reason for the low corporate identity with HealthCo as an organisation among the health care professionals in these business units.

5.7 Networks and meetings

The leadership course in business area Primary Care results in a network among the health care professionals. With the network they can come in contact with other health care professionals with managerial responsibility and they are made aware that there are other managers in the same position with the same economic responsibility as they have. Knowing that there are other managers in the same position facilitates the hybridisation process since they can seek input and support from others with the same ideological background and experiences as themselves. This makes it less 'frightening' to take on even more financial and managerial responsibility and thus enhances the hybridisation process.

Business area Geriatric's leadership forums stimulate exchange of ideas between unit management and the administrative professionals. These forums lower the barriers between professions and stimulate the creation of a common language and a commitment to each other's agendas, and open up for communication between the professions. These forums have foremost been an arena for head unit nurses where they have been able to receive praise for taking on own initiatives regarding increasing efficiency in the units. However, the medical responsible physicians have not been as active at these forums. As mentioned before, the head unit nurses may have used these forums to strengthen their professional position in relation to the physicians (Blomgren, 2003). In this case, the forums can enhance the hybridisation process for the head unit nurses since they take on more technocratic controls, however, since

the physicians are reluctant to take on an active role at the meetings, their process of hybridisation is not enhanced.

The absence of meetings and interaction between Artro and the HealthCo group has resulted in less knowledge sharing with HealthCo. This has made it hard for Artro's managers to contrast their values with the values of HealthCo in general, which in turn increases the distance between the HealthCo group and Artro. However, internally there are platforms for knowledge sharing between professions. One example is the daily breakfast in which all health care professionals and administrative professionals meet. These informal meetings are emphasised by one of the unit managers as good opportunities for the professions to approach each other, and as a consequence the relationship between the controller and the unit manager is strengthened. The meetings give the unit manager a possibility to discuss the financial measures on a daily basis. Altogether, the unit manager admits that the close relationship with the controller is vital in order for her to take on financial responsibility, and thus, these informal meetings are at least partly important for the process of hybridisation.

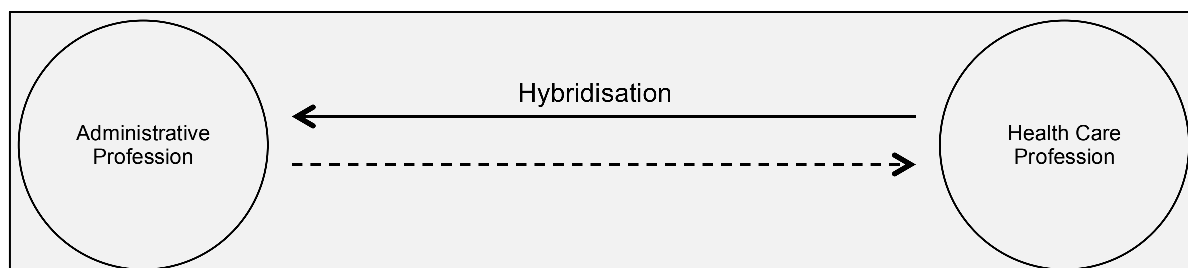
6. Discussion

The analysis of the empirical observations in the three business areas in HealthCo, reveal that there are several findings adding to the current understanding of the hybridisation process. These findings will throughout this section be further discussed in relation to each other and in relation to previous research. This discussion will finally result in a conceptualised illustration of a five-stage model of the hybridisation process as a conclusion of the present study.

6.1 Interfaces of control

Reflecting upon management controls and their interdependence as evidenced in the analysis, there is evidence that the interfaces of technocratic and socio-ideological controls affect the hybridisation process in a private health care organisation. It is when the technocratic and socio-ideological controls facilitate a common language between health care and administrative professionals that the organisation achieves an organisational conformity with mutual trust between professions. This finding is in line with previous research emphasising the importance of alignment between costing and caring in order to facilitate an acceptance of technocratic forms of control (Llewellyn, 1998). There is evidence to suggest that technocratic control could not work within its original purpose without the support of the socio-ideological control. It seems like there is not only health care professionals engaging in the accounting profession. The administrative professionals also engage in the health care profession and it appears that this process is of vital importance in facilitating the hybridisation process. Since the initiative to increase control generally comes from management as a consequence of pressure (e.g. financial, see e.g. Dent, 2003), the manner in which administrative professionals initiate changes is critical. Through learning about the health care practises, administrative professionals can reliably show how increased management control can be of an advantage for improving health care services. It is when the administrative professionals, e.g. controllers, use a medical language in discussions or when explaining financial aspects that financial implications are operationalised. However, it would be misleading to call the transformation of administrative professionals hybridisation. Even though the controllers in HealthCo gain knowledge about medical treatments and their financial implications, they cannot take on the role of health care professionals in treating patients. However, knowledge transferred from the health care profession to the administrative profession does affect the hybridisation process. Accounting is a tool rather than a profession in line with Kurunmäki's (2004) argumentation, and the present study show how accounting is used as a tool and technique for management control within the health care profession. This relation between the two professions are illustrated in the below model.

Figure 6. Knowledge exchange between the health care profession and the administrative profession

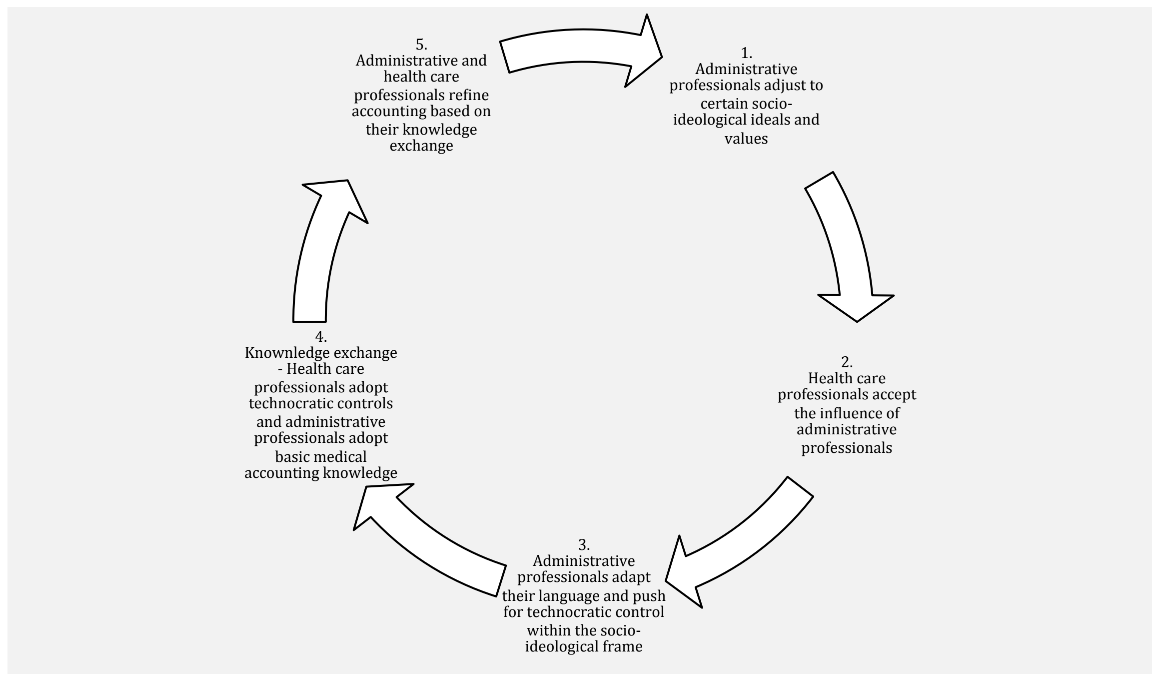


The figure illustrates the mutual knowledge exchange between the administrative and the health care profession. While the health care profession hybridise, acquiring accounting knowledge and techniques, the administrative profession acquire knowledge of the financial implication of health care operations.

Observations from the empirical data indicates that the hybridisation process is a continuous and dynamic process. Hence, even though health care professionals have become hybridised, this hybridisation can cease if the interface between socio-ideological and technocratic control is interrupted. Interruption may occur as a result of many factors, such as recruitment of a new manager with deviating socio-ideological values or from a change in organisational structure. The view of hybridisation as a *process* rather than a *static* description of the transfer of knowledge in the creation of a hybridised health care professional, adds a new dimension to how findings from previous research may be understood in a private health care organisation. Previous research such as Kurunmäki (2004) and Kurunmäki et al. (2003) studied hybridisation from a more static perspective arguing that hybridisation either has or not has occurred. The static view of hybridisation has two consequences. First, it does not pay attention to that hybridisation is a continuous process, and does not consider the fact that hybridisation may be interrupted or even ceased, although it initially occurred. Second, the static view overlooks the evolution of accounting throughout this process and in relation to the context where it is being used, in this case the private health care organisation.

The process of hybridisation that is identified in the empirical data of this study may be divided into five different parts, in which all are equally important for a successful process. First, there is a need for the administrative professionals to adjust to certain socio-ideological ideals and values that can be shared with the health care professionals. Second, when the health care professionals are made aware of the fact that they share values with the administrative professionals, it becomes easier for them to accept the influence of the administrative professionals in their daily work. Third, when the health care professionals have accepted the influence from administrative professionals, the administrative professionals can "push" for increased use of technocratic controls within the socio-ideological frame. At this stage, there is also a need for the administrative professionals to enhance their communication with the health care professionals through adaption of a certain accounting-medical language. Fourth, health care professionals adopt technocratic controls e.g. management accounting tools and techniques, while the administrative professionals adopt basic medical accounting knowledge, meaning knowledge concerning the financial implications of the health care operations. This fourth step is illustrated in Fig. 6 above. Fifth, the administrative and health care professionals refine and adapt the accounting tools and techniques to better reflect the health care operations. The hybridisation process is illustrated in Fig. 7 below.

Figure 7. The process of hybridisation



This figure illustrates the five-step model of the continuous process of hybridisation.

6.2 The five-stage model of the continuous process of hybridisation

Each of the five steps in the hybridisation process will now be discussed and contrasted with findings of previous research. At each stage examples will be given from when the interface between technocratic and socio-ideological control is interrupted and how this interruption affects the process of hybridisation.

Stage 1. Administrative professionals adjust to ideals and values

When initialising a process of hybridisation the empirical data indicates that administrative professionals tend to adjust their socio-ideological ideals and values to be consistent with the health care professionals'. Through different forms of socialisation processes, the administrative professionals are able to demonstrate motivation to adhere to the core values of the medical organisation. Socialisation processes are important for getting acceptance for new control functions as also stated by Abernethy and Stoelwinder (1995). It is evident that the administrative professionals reassess their professional position from being holders of abstract knowledge and professional titles, to a role were they see themselves as providers of support and encouragement. There are several examples of this in the empirical data, e.g. decentralisation of budget preparation and accountability for financial results. These findings are in line with Llewellyn (1998) who found that decentralisation of budgeting work and accountability lowered the boundaries between costing and caring.

In the empirical data there are examples when the first step in the hybridisation process was interrupted. Interruption occurred when a newly appointed administrative professional pushed for ideas that were not in line with the medical ethics of health care professionals. This mismatch had consequences for the second stage in the process of hybridisation.

Stage 2. Health care professionals accept the influence from administrative professionals
The second stage in the hybridisation process depends upon the willingness of health care professionals to accept the influence of administrative professionals. Hopwood (1974) argues that:

> If the rules are to be followed, they must be reinforced, accepted and acted upon. They must, either directly or indirectly, become the rules of the managers and employees rather than the rules of the enterprise. Ultimately they must work as individual and social controls rather than as impersonal administrative devices. (Hopwood, 1974, p. 21)

Hence, if the rules of the administrative professionals are to be accepted and acted upon, they must work as individual and social controls for the health care professionals. The empirical findings confirm that if technocratic controls are to be accepted and acted upon by the health care professionals, the controls are to be adjusted to the socio-ideological values of medical care. Even though Hopwood (1974) argues that the administrative professionals in some cases may use coercive means or material rewards, the empirical findings suggest that these methods do not work sufficiently when it comes to health care professionals. Instead, in order to have the health care professionals accepting the rules, they need to be able to identify their own core socio-ideological values in both the administrative professionals' behaviour and the technocratic controls.

Another factor affecting the willingness of health care professionals to accept involvement of administrative professionals is transparency in the financial reporting. An important finding in this study is that increased transparency is one of the advantages that motivate health care professionals to become hybridised. The empirical data show that transparency works as a legitimising tool for the health care professionals. In the case of HealthCo, the health care professionals demand better insight in the financial situation in order to be assured that HealthCo does not earn excessive returns at the cost of patient safety, quality and the working environment of staff. Transparency was also sometimes seen as a prerequisite before being employed by the private health care company. This demand for transparency probably originates from the political and societal debates about previous scandals and discussions concerning profits in the social welfare sector.

Deviating socio-ideological norms between the health care professionals and the administrative professionals, as mentioned above, provide an example of when health care professionals do not accept the influence from administrative professionals. Kurunmäki et al. (2003) and Kurunmäki (2004) would view the health care professionals as hybridised in accordance to their more static definition of hybridisation. However, the emphasis on hybridisation as a continuous process understands the process as being interrupted and that the attempts to affect the prevailing technocratic system would have been unsuccessful. The decoupling between the administrative professionals and the health care professionals did however not interfere with the internal hybridisation since the health care professionals already had the necessary administrative professionals internally, and also had developed technocratic controls that were built upon their own values. Thus, the decoupling did not inhibit their internal process of hybridisation. However, assuming that the newly appointed administrative professional had relevant accounting tools and techniques that could benefit the health care professionals, these technocratic controls would have difficulties to be mobilised and absorbed by the health care professionals.

3. Administrative professionals adjust their language and push for technocratic control
Stage three in the process of hybridisation occurs when the health care professionals have accepted the influence of the administrative professionals. In this step, administrative professionals push for technocratic control. If this stage does not follow after stage one and two, and instead that technocratic controls are pushed without being embedded in the socio-ideological values of the health care professionals the result can be decoupling. Previous studies have found that decoupling occurs when there is a fast implementation in combination with a strong push for technocratic controls (see e.g. Kurunmäki et al., 2003). However, these studies found that decoupling may not always affect hybridisation, and health care professionals may still become hybridised even if decoupled at organisational level. This argument stems from the perspective of hybridisation being a static process. However, if hybridisation is seen as a dynamic process based on the interaction between technocratic and socio-ideological controls, then a decoupling may interrupt this interface. The empirical findings confirm that the process of hybridisation in a private health care organisation is dependent on an active relationship between both professions, in which the administrative profession takes on a supportive role for the health care profession. In such a setting decoupling will not occur since both professions have a supportive rather than defending relationship.

An important factor for the hybridisation process is how the organisational structure gives support for engaging in technocratic forms of control (Jacobs, 2005). A structure in which one controller and one medical responsible physician support the health care professional, appears to facilitate hybridisation. In this environment, the health care professional receives both support and "push" to assimilate accounting tools and techniques in their daily work. Simultaneously, the medical responsible physician assures that good quality care is delivered. Through this organisational set-up, the interfaces of technocratic and socio-ideological controls create an environment that fosters hybridisation. In contrast, it seems like the traditional structure of the health care organisation in which health care professionals are hierarchically divided into different groups, discourage hybridisation because costing and caring are not aligned to each other (Llewellyn, 1998).

Communication through a common language is another important factor that is related to the organisational structure. In order to push for increased use of technocratic controls, clear and understandable communication is needed. Empirical data confirm that communicating technocratic controls to professionals that are not used to "accounting language" demand pedagogic skills. Good communication and a genuine interest in health care facilitate the work of controllers. Through their supportive role and also their adjustment to the values of the health care professionals, they are able to develop an "accounting-medical" language. This accounting-medical language has two consequences for the process of hybridisation. First, it makes it easier for the controllers to provide support since they are much easier understood. Second, the willingness to adapt to the medical environment, signals that the administrative professionals are there to support the health care professionals and not to burden them. This willingness to adapt to the socio-ideological values of the health care professionals reinforce stages one and two above.

The socio-ideological frame that the administrative professionals adjust to under stage one dictates to what extent they may push for technocratic controls. However, different pressures, external or at corporate level, may weaken this socio-ideological frame, and result in a faster and stronger push for the implementation of technocratic controls. The introduction of a Healthcare Choice reform is an example of when the administrative professionals have used

external pressure to push for technocratic controls in a way that had not been possible without support from the reform. This finding is in line with Llewellyn (1998) who found that financial squeeze on the public sector helps breaking down the barriers between costing and caring. However, previous studies do not highlight the correlation between the type and degree of pressure and the manner of implementation. This difference may partly be described by the more static approach to hybridisation used in previous studies. The current process approach, built on empirical findings, suggests that a faster implementation of technocratic controls is possible, provided the administrative professionals have aligned their socio-ideological values to those of health care professionals. Prior studies show that a high degree of pressure and a fast implementation may result in temporary hybridisation although the basic values of the health care professionals are not considered. However, as the pressure ceases there may be a backlash in that health care professional will reclaim professional autonomy (Dent, 2003).

When pushing for technocratic control within the socio-ideological frame, the administrative professionals can use different ways of making the linkage between costing and caring more obvious. Variable compensations tied to both qualitative parameters and the financial result has been shown to be a factor linking socio-ideological controls with technocratic controls, in which health care professionals could ensure themselves that a positive financial result could only be delivered through the achievement of a high quality. In this way the technocratic controls gives equal attention to both social and financial factors, which in turn may enhance the process of hybridisation. This finding is in line with Kurunmäki and Miller (2006) who argue that the process of hybridisation may be discouraged if too much attention is given to the financials.

Regarding the influence of the workings of the care operations, Kurunmäki et al. (2003) argue that the workings within the intensive care units of their study, which involved strong teamwork, may obstruct hybridisation. In the empirical data it is evident that when the complexity of care is low, then it is easier to construct a technocratic output control that reflects reality. When complexity increases, and especially when it is hard to measure individual performance, it becomes harder to visualise the linkage between cost and caring. When the care operations are complex but allow individual measurement, it becomes easier to construct more appropriate technocratic controls. However, when the complexity is high, even more emphasis has to be placed on the relationship between the administrative professionals and the health care professionals in order to develop the system. In such cases, the fact that the health care professional has accounting knowledge may facilitate the process. Consequently, the clearer the linkage is between input and output, in combination with the accounting competence of the health care professional, may be vital in order to develop technocratic controls that are built upon the socio-ideological frame, and thus, that the process of hybridisation can continue.

There are empirical examples of when push for technocratic control is not done within the socio-ideological frame, leading to an interruption of the hybridisation process. It is evident that if the interfaces between the technocratic and the socio-ideological controls are not made clear from the beginning, interruption occurs. This is particularly the case when there is no pressure that can weaken the socio-ideological frame. Then it becomes even more critical for the administrative professionals to ensure that the technocratic controls will not offend the socio-ideological values of the health care professionals.

4. Health care professionals transform and administrative professionals support
Stage four in the process of hybridisation occurs when the health care professionals have adopted the technocratic controls as a result of push from the administrative professionals. When approaching hybridisation from a more static approach, it is in this stage that hybridisation is said to occur, and hence, where the health care professional takes on tools and techniques from the administrative professionals (Kurunmäki et al., 2003; Kurunmäki, 2004). The hybridisation process as described in previous research is in line with the process-based approach to hybridisation, however, this approach is dependent on all stages in the process and appear to be continuous rather than being accomplished.

Empirical data confirm that the health care professionals transform in tight collaboration with the administrative professionals, controllers in particular. They have a supportive function and assist the health care professionals to transform from the role of medical expert to the role as a medical accountant although keeping their socio-ideological values of how health care should be provided. This close relationship between the health care professional and the administrative professional is not as clearly observed in previous studies. Kurunmäki et al. (2003) and Kurunmäki (2004) found that the hybridisation of health care professionals in Finland was to a large extent driven by health care professionals themselves, and the relationship with other professions was not as obvious. In some cases there were even a decoupling between the health care professionals and the administrative professionals. Empirical findings in this study shows that the initiative to start the process of hybridisation came both from the very top management, however the willingness to approach technocratic controls were in some way present with the health care professionals since employees with an interest of financial measures were recruited to the company.

The increased need for transparency in company financials, as mentioned under stage two, became again important during the transformation of the health care professionals. Empirical information showed that the process of hybridisation was enforced if the health care professionals were given full insight into the financials. If transparency before was important in order to legitimise the private health care company, it now became important from the perspective of the individual health care professional. From being used for legitimising the company, transparency was now demanded in order to legitimise their own actions in the company, and to verify that their new role as hybridised health care professionals did not violate the socio-ideological values of their profession. In other words, they used the accounting tools and techniques to legitimise their work and to prove it resulted in better quality for their patients, and not only generated profits for the owners. The demand for insight and understanding of the financial situation increased to such an extent that some of the health care professionals saw it as a natural part of the monthly follow-ups to access this kind of information. Taking part of the monthly financial result became a natural part of one's work and it was not seen as abnormal to incorporate such information in meetings that usually focused on medical issues, it was rather seen as part of everyday work when you are employed in a private health care company to take part of such information. In that sense, hybridisation was not seen as anything unusual, it was rather seen as the responsibility of everyone involved, and almost a natural part of the health care profession.

The collaboration between the administrative professionals and the health care professionals had also consequences for the former. Through their supportive role, they engaged in the health care operations and acquired knowledge concerning financial implications of the health care operations. Further, this understanding of the actual operations improved the accounting-medical language used in the knowledge exchange between administrative and health care

professionals. Although the administrative professionals already had adjusted to the socio-ideological frames of the health care professionals at stage one in the process, it was first during this stage that they were given access to learn about the medical operations.

As well as the health care professionals may become hybridised at the fourth stage, the process of hybridisation may also end here, with the consequence that the health care professional quit the hybridisation process. The empirical observations have shown how a hybridised health care professional became tired of the financial responsibility and returned to the normal role as a health care professional. From a static perspective the health care professional may continue to be hybridised, but from the process perspective of hybridisation, the interface between the technocratic and the socio-ideological controls comes to an end since the health care professional is no longer able to affect the technocratic controls based on the health care professional's socio-ideological values.

5. Accounting is refined by administrative and health care professionals

The more static approach to hybridisation as referred to by Kurunmäki et al. (2003) and Kurunmäki (2004) emphasise that when the health care professionals have been hybridised, this is a consequence of that the accounting tools and techniques have been mobilised to the profession, and hence, used in their daily planning and execution of the operations. However, from these studies it is unclear whether accounting is viewed as a static tool or if it in some way may be refined in order to better reflect the actual health care operations. If hybridisation instead is viewed from the process perspective discussed here, then it becomes evident from the empirical data that the accounting techniques may transform within its original purpose and develop during the hybridisation process, partly as a consequence of the collaboration between the health care professionals and the administrative professionals. The fifth stage in the process of hybridisation is thus an outcome of the four other stages, in which the knowledge exchange between professions is used to refine the accounting. There are several examples of when technocratic controls, such as variable pay systems and KPI's, have been changed on request of health care professionals. A prerequisite for the refining of accounting practises has been a supportive approach from the administrative professionals in which they have been accepted by the health care professionals and given access to the process of hybridisation. One may question if the presence of the administrative profession really is necessary to develop the accounting techniques? In this sense, Kurunmäki et al. (2003) argues that a decoupling between the professions may foster hybridisation. However, evidence from the empirical data suggest that many of the health care professionals would not have been engaged in a hybridisation process if they were not given support to understand the financial language from the administrative profession, and further, they admitted that they would have had difficulties to refine the technocratic controls if they were not given support from the controllers. Although, it should be emphasised that it is not the administrative profession who develops the technocratic controls, the health care professionals, who are supported by administrative professionals when needed, are responsible for refining the accounting. In this sense, decoupling between the professions would not contribute to the process of hybridisation. The finding of previous studies may be a consequence of a more static view of hybridisation.

In addition to Kurunmäki et al. (2003) and Kurunmäki (2004), accounting knowledge may not only be transferred to and mobilised by the health care profession, but also refined by the health care profession in order to better suit the health care practises. In this sense, the possibility for the health care professionals to develop the technocratic controls gives them

greater assurance that the financial measures are based on their own norms of how health care operations should be carried out.

When the administrative professionals decided upon implementing common KPI's that should be used in the evaluation of all units, this interrupted the fifth stage in the process of hybridisation, since the health care professionals were not given the possibility to refine these accounting tools themselves. When this occurred, the result was not only a low commitment to start using and evaluating the result of the KPI's, there was also a concern regarding if the administrative professionals had understood the medical practises, and if they had adjusted their socio-ideological values in accordance to the health care professionals', step one in the process of hybridisation. This interruption in the hybridisation process was usually managed through allowing the health care professionals to redesign the KPI's in order to suit the actual operations better.

7. Conclusion

7.1 Conclusion – the knowledge exchange between professions

The overall aim of the present study was to increase the understanding of hybridisation in a private health care organisation. The sub-purpose of the study was to increase the understanding of how interfaces between technocratic and socio-ideological controls affect the process of hybridisation, and how this process can contribute to the refinement and development of accounting. Five main conclusions could be identified and the practical implications of these will be discussed in this section. This is followed by a discussion on the study's limitations and suggestions for future research.

First, it can be concluded that the interfaces between technocratic and socio-ideological control facilitates a common understanding between the health care professionals and the administrative professional that fosters the process of hybridisation. Second, adding to prior research, it is found that this process not only involves the health care professionals absorbing technocratic controls. An even more important aspect is that the administrative profession acquires knowledge and adapts to the values of the health care profession. This suggests that the process of hybridisation is to be interpreted as a knowledge *exchange* rather than a knowledge *transfer*. Important for this process is the development of a common language (terminology) between health care and administrative professionals.

Third, it is in the interface between technocratic and socio-ideological controls that the preconditions for hybridisation are created. Several factors are found to be preconditions for the process of hybridisation. In the study, transparency is found to be such a factor that affects the process of hybridisation. Transparency is not only a factor used by the administrative profession to achieve management control in the organisation. Transparency is also used by the health care professionals as a legitimising tool for both the private health care organisation as such, and to legitimise the actions that they perform working as health care professionals with technocratic controls. This finding is closely related to the organisational environment of the present case study. Considering that private health care organisations have been questioned in the public debate, it becomes important for the private health care organisation, in contrast to the public health care organisation, to be transparent and to align technocratic controls with the norms of the health care professionals in order to facilitate hybridisation. Further, this "dual" transparency, when the health care professionals matches their socio-ideological norms with the technocratic controls, is found to become part of their everyday work. To conclude, the need for transparency in order to legitimise the role of the health care professionals in the private health care organisation results in accounting knowledge being part of the everyday work of the health care professionals. This results in the phenomenon of accounting being integrated to such an extent in the workings that the health care professionals do not reflect upon that they undergo hybridisation.

In addition, another important factor found to be a precondition for the process of hybridisation is the manner of implementing changes in the organisation. In the study, the degree of "pressure", for e.g. improved financial performance or improved quality, is seen as a critical precondition for the fulfilment of the hybridisation process. A high degree of pressure facilitates the process of hybridisation. However, it is also found that a slow implementation of accounting techniques in combination with a low pressure, may lead to insecurity among the health care professionals, and thus discourage the process of

hybridisation. This finding calls for more research on the manner of implementation and suggests a broader perspective on the environment in which accounting knowledge is being implemented.

The differences in the care provided in the three business areas analysed, Primary Care, Geriatric and Artro, were also found to be a factor influencing the hybridisation process. A low complexity of care implies that it is easier to design an output measurement system that can be reliably understood by the health care professionals and to visualise the input-output linkage in clinical practises. In complex care situations, there are limited possibilities for individual measurement due to care delivered in teams of professionals, or that the diagnose in itself makes it hard to determine what treatment gives the best effect. This creates challenges when constructing an output measurement system that reflects the actual practises. In the study, it is found that a system with an unclear linkage between input and output results in less motivation for the health care professionals to "accept" the technocratic controls, which in turn hampers the process of hybridisation.

The relationship between the health care professionals and the administrative professionals found in the present study is to be seen largely as a result of an organisational structure in which the administrative professionals support the health care professionals. This finding implies that organisational structure constitutes an important factor affecting hybridisation. It can be concluded that the traditional organisational structure of the health care organisation, separating the health care professionals from the administrative professionals, counteracts the process of hybridisation.

The fourth conclusion from the study is that the process of hybridisation causes accounting to change, develop and refine in order to better reflect the environment of the private health care organisation. This finding confirms Kurunmäki's (2004) view that accounting has the characteristic of being a craft rather than a profession of abstract knowledge. However, in order to fully understand the development of accounting, there is a need to view hybridisation as a continuous process of knowledge exchange, rather than a static description of professional roles. The study found that the interfaces between technocratic and socio-ideological controls, together with the factors that affect the hybridisation process could be conceptualised into a five-step process of hybridisation. This fifth and final conclusion states that when hybridisation is studied from the process perspective, it is confirmed that the process can be interrupted and even ceased at any stage. In this sense, the process of hybridisation never comes to an end; it is a continuous exchange of knowledge between professions. This process perspective of hybridisation is vital in order to understand how accounting can be refined through the exchange of knowledge between professions. Thus, studying hybridisation from a process perspective provides a base for understanding the evolution of accounting in relation to the context in which it is being used. Or in the words of Hopwood (1983):

> Accounting is neither a static nor a homogenous phenomenon. Over time, all forms of accounting have changed, repeatedly becoming what they were not. […] All too apparently accounting is a phenomenon, which is what it isn't and can become what it wasn't!
> (Hopwood, 1983, p. 289)

7.2 Limitations with the present study and potential areas for future research

As discussed in the third section (3. Method), one limitation of the present study concerns the qualitative research method. Since the empirical data is based on interviews, the fact that human behaviour changes over time makes it impossible to give a perfect reflection of reality in the empirical description. In addition, it must be taken into consideration that the authors own interpretations may have affected the empirical findings of the study. However, the method of the study has been carefully chosen in order to strengthen the reliability of the empirical data.

A second limitation concerns that a single case study is conducted, which limits the possibility to draw generalisable conclusions from the findings. However, this creates potential for future research to perform a similar study, but of several health care organisations. Adding a quantitative research method to support the case studies could as well result in further insights. In addition, it would be interesting to perform a comparative study including both privately and publicly owned health care organisations. That would portray how the ownership structure affects the hybridisation process. In addition, since one of the main findings of this study is that there is much to be gained from studying hybridisation from the perspective of a continuous process, it would be interesting to follow the interviewees over a longer period of time. As several studies of hybridisation have gained valuable insights from comparing health care organisations in different countries, it would be of interest to also add the continuous process perspective of the present study to these types of studies.

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Appendix 1. Conducted interviews

Role	**Physical/Video**	**Date**
Pre-study		
CEO HealthCo	Physical	2013/02/15
Physician (external)	Physical	2013/02/15
Business area manager	Physical	2013/03/05
Physician (consultant, external.)	Physical	2013/03/13
Main study		
HealthCo		
CEO	Physical	2013/03/13
CFO	Video	2013/04/09
Primary Care		
Business area manager	Physical	2013/03/19
Regional manager	Physical	2013/03/21
Buisness area manager	Physical	2013/03/27
Unit manager	Physical	2013/03/27
Unit manager	Physical	2013/03/27
Business area CFO	Video	2013/03/28
Chief Medical Officer	Video	2013/04/02
Controller	Physical	2013/04/03
Unit manager	Physical	2013/04/05
Assistant nurse	Physical	2013/04/05
Physician	Physical	2013/04/10
Unit manager	Physical	2013/05/07
Unit manager	Physical	2013/05/07
Unit manager	Physical	2013/05/07
Unit manager	Physical	2013/05/07
Geriatric		
Business area manager	Physical	2013/03/26
CEO	Physical	2013/04/04
Business area CFO	Video	2013/04/05
Controller	Physical	2013/04/11
Head unit nurse	Physical	2013/04/16
Nurse	Physical	2013/04/16
Medical Responsible Physician	Physical	2013/04/16
Chief Medical Officer	Physical	2013/04/19
Artro		
CEO	Physical	2013/04/03
Business area manager	Physical	2013/04/10
Physician	Physical	2013/04/10
Controller	Physical	2013/04/11
Health care manager	Physical	2013/04/11
Unit manager	Physical	2013/04/12
Unit manager	Physical	2013/04/16