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Control in a public-private partnership with multiple inter-organizational relationships

A case study in the Swedish healthcare sector

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Abstract

This thesis investigates the ongoing use of controls in a public-private partnership (PPP) within specialized healthcare in Sweden, resulting in three inter-organizational relationships. Through an in-depth qualitative case study using Hopwood's (1974) framework of controls the use of controls in the ongoing operations is examined. In a second step, Dekker's (2004) control problems of appropriation concerns and coordination requirements are applied to explain the use of inter-organizational controls. It is concluded that administrative-, social- and self controls played a role in all three inter-organizational relationships, although the balance between the controls and their respective importance varied. Similarly, both appropriation concerns and coordination requirements contribute to explaining the inter-organizational controls in all three relationships. In particular, social- and self controls significantly mitigated appropriation concerns and coordination requirements. The varying balance of controls in the three inter-organizational relationships within the same PPP further underlines the value of going beyond the traditionally dyadic approach to PPP research, especially in the complex PPPs often found within the healthcare sector.

Keywords: Inter-organizational control, Public-private partnership, Specialized healthcare
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1. Introduction

One of the western hemisphere's most fundamental societal distinctions is the boundary between public and private (Weintraub, 1997). Yet, many activities take place between what we traditionally know as the public and private sector today (Lindberg and Blomgren, 2009). According to Drache (2001), a public domain is emerging where public and private is integrated and boundaries between the sectors become less clear.

Lindberg and Blomgren (2009) observe the same development within health- and medical care in Sweden, a sector that has increasingly come to include private alternatives for ownership, operations and financing during the last decennium. Furthermore, health- and medical care is at start a complex sector that continually faces complex challenges that cannot be managed by any isolated unit or professional group (Lindberg and Blomgren, 2009). An increasing number of sub-specializations within healthcare have resulted in greater division of labor and specialization within the professional groups, contributing to fragmentation in the sector (Lindberg and Blomgren, 2009; Öhrming, 2008). The number of separate units dependent on each other has therefore increased, and organizational as well as professional boundaries need to be crossed in care delivery (Lindberg and Blomgren, 2009).

In short, the increasingly fragmented healthcare sector and the increase of private actors result in a dynamic where boundaries continuously change, are reconstructed and crossed – a dynamic that affect how healthcare organizations are managed and controlled (Lindberg and Blomgren, 2009; Öhrming, 2008). In fact, healthcare politicians have expressed their job as centered around managing and taking responsibility for operations that cannot be demarcated or controlled (Blomgren and Sahlin-Andersson, 2003; Öhrming, 2008). Against this background, healthcare is deemed an empirically relevant and intriguing sector for studying public-private inter-organizational control.

1.1 Existing research and knowledge gaps

Looking at previous research streams within accounting and control, the body of research focused on control in the inter-organizational setting has grown since the mid-90s. Research has evolved in two streams: (i) a larger stream with empirical focus on the private sector (Dekker, 2004; Caglio and Ditillo, 2008), and (ii) a parallel smaller stream of research focused on the public sector (Kraus and Lindholm, 2010).

However, there is also a body of literature that is focused on one specific type of inter-organizational relationship – the public-private. It is centered on the increasingly common organizational structure called public-private partnership (PPP), in which public sector services are being handled by private actors (Lambert and Lapsley, 2006). The PPP implies that the public sector and the private sector are working together within the frame of a contractual agreement (Kraus and Lindholm, 2010). In practice, the private actor delivers services to the public sector,

while the public sector retains the overall responsibility for service provision (Kraus and Lindholm, 2010). Moreover, the PPP is generally treated as a dyadic inter-organizational relationship. However, this perspective overlooks the fact that a PPP in practice may involve relationships between several organizational units.

In setting up and operating PPPs, accounting is a central mechanism that has a significant role (Lambert and Lapsley, 2006). The accounting literature in this field has largely focused on the details and mechanisms of PPPs, related policy and the contract at such (Lambert and Lapsley, 2006; Andon; 2012). This encompasses the rationale of PPPs, processes and procedures for evaluation of PPPs, policy issues, and accounting disclosure. Moreover, previous research has focused more on accounting and control issues related to the procurement contract and the direct or early outcomes of PPPs (English and Baxter, 2010; Andon, 2012). Therefore gaps in the current research involve studies on the operationalization of PPPs and the ongoing use of accounting and control (Andon 2012; Kraus and Lindholm, 2010). Furthermore, suitable future research topics involve examining the interplay between accounting and "a range of actions, interest, social processes and meanings that frame and affect tasks beyond the financial" (Andon, 2012).

A second area where more research is needed regards the contradictions between the contractual governance and need for cooperation that simultaneously characterize PPPs (Broadbent, 2003, cited in Andon, 2012; Edwards and Shaoul, 2003; Reeves, 2008). As cooperation is seen as a success factor, several studies have pointed to the role of previous relations and trust-building as important complements to contractual control (Andon, 2012, Reeves, 2008). The empirical findings do, however, diverge and suggest that the importance of trust differ depending on the situation at hand, which suggest that its role is more complex than inferred by theory (English and Baxter, 2010; Andon; 2012).

Finally there has been a large empirical dominance from UK and Anglo-Saxon researchers and study contexts (Broadbent and Laughlin, 2004; Grimsey and Lewis, 2004, as cited in Andon, 2012). Hence, to be able to compare and contrast findings and gain knowledge that is internationally generalizable, research contributions from other geographies of the world are required (Andon, 2012).

1.2 The aim of the thesis

Against this background of previous research on control and accounting within public-private partnerships (PPPs), the thesis aims to investigate the ongoing use of controls in a PPP within the healthcare sector in Sweden, involving one private counterpart and three inter-related units in the public counterpart. Thereby, we go beyond the traditionally dyadic approach to PPP research, and include three inter-organizational relationships resulting from one PPP. These empirics bring the study closer to a common context of PPPs, which are often embedded in a larger context of public sector organizations.

In order to examine how control is used in the ongoing operations in healthcare delivery, it is important to recognize the specific characteristics of the healthcare sector and the potential

impacts on control. Such traits include strong professions along with dominant focus on what is best for the patient (Lindberg and Blomgren, 2009; Kraus and Lindholm, 2010). A broader approach to control is therefore taken by applying Hopwood's (1974) framework, extended into the inter-organizational setting. This is in line with the broad conceptualization of control advocated by several researchers (Hopwood, 1974; Caglio and Ditillo, 2008; Van der Meer-Kooistra and Scapens, 2008). Hopwood's (1974) framework encompasses three types of control: administrative-, social- and self controls. Administrative controls include managerial efforts to influence outcomes and employee behavior (Hopwood, 1974, ch. 2). However, doctors, nurses and administrative personnel operating in healthcare are also influenced by their social interaction at work. Therefore, social control refers to the influence of shared group norms and values on an individual's behavior (Hopwood, 1974). In addition, individuals are affected by their gut feeling of what consists the right behavior is at any given moment. Self controls are therefore included as a third form of controls, encompassing an individuals' personal instincts, motives and values and its effect on behavior (Hopwood, 1974). While these three types of controls may at times be aligned and advocate the same behavior from the employee, they may in other occasions generate opposite control impulses (Hopwood, 1974). Choosing a control framework that includes all three types of controls, is therefore considered useful for the empirical setting of ongoing healthcare operations.

In a second step of analysis, it will be investigated how the use of controls can be explained by the control problems outlined by Dekker (2004). The two control problems include appropriation concerns, from transaction cost theory, and coordination requirements from organizational theory. Firstly, appropriation concerns imply a concern to safeguard ones investment from being appropriated by the potentially opportunistic other part in an inter-organizational relationship (Dekker, 2004). However, transaction cost economics and appropriation concerns have been concluded to lack in explaining the full picture of inter-organizational control, and Dekker (2004) argues that coordinating interdependent tasks between partners is an additional control requirement. Therefore the theoretical framework will combine Hopwood's (1974) framework and the control problems of appropriation concerns and coordination requirements outlined by Dekker's (2004).

In short, the following research questions will be investigated:

1) How are administrative-, social- and self controls used in the ongoing healthcare operations in three inter-organizational relationships resulting from one public-private partnership?
2) How can the use of inter-organizational controls be explained by appropriation concerns and coordination requirements?

The research questions are investigated based on an in-depth qualitative case study of specialized healthcare provision in Sweden, encompassing 22 interviews. The primary study object is a Nordic private healthcare group, henceforth called Healthcorp, and more specifically its subsidiary referred to as HealthcorpSub. HealthcorpSub has been delivering orthopedic specialized care at a hospital in a Swedish county, henceforth called Niceville County, since 2009. Three relationships in its inter-organizational context make up the empirical basis for the case

study. These relationships with HealthcorpSub include: (i) a publically managed clinic at the same hospital (ii) a publically managed clinic supplying the same care at a neighboring hospital in Niceville County and (iii) the Niceville County Management. In order to get a holistic perspective on the controls employed from the ongoing healthcare operations and upwards in the hierarchies, interviews have been done with HealthcorpSub management, Head of Clinics, doctors, nurses, accountants and county administrators and managers.

1.3 The structure of the thesis

The thesis is structured as follows. In the first section, a description of previous literature is provided and research gaps pointed out in order to give an understanding of the setting of our study. Against this background, the theoretical framework chosen for analysis of the empirics is also motivated and described. Secondly, an account of the method applied in the thesis is given. Thereafter, we present the case analysis, in which the empirical material is analyzed using the control framework of Hopwood (1974). In the second step of analysis, in the discussion, Dekker's (2004) control problems of appropriation concerns and coordination requirements are applied to explain the use of controls. Lastly, the thesis is summarized in the conclusion, where we also reflect on limitations and future research topics.

2. Review of previous literature

In the below section, we review and present previous research within the relevant fields of our study. The section aims to theoretically motivate the research topic chosen as well as to build a theoretical framework for analysis.

2.1 Different research streams in relation to public sector trends

As mentioned above, the body of research focused on control in the inter-organizational setting can be divided into two streams: (i) a larger stream with empirical focus on the private sector (Dekker, 2004; Caglio and Ditillo, 2008), and (ii) a parallel smaller stream of research focused on the public sector (Kurunmäki and Miller, 2006; Kraus and Lindholm, 2010; Carlsson-Wall et al., 2011).

However, several trends contribute to merging and creating gray zones in what is traditionally known as the private- and public sector. Two such recent trends, which have created tensions by their parallel influence on governance, control and accounting within the public sector, are inter-organizational cooperation and New Public Management (Kraus and Lindholm, 2010). Firstly, increased cooperation is advocated in the public sector as a means of increasing efficiency (Kurunmäki and Miller, 2006; Lambert and Lapsley, 2006). Secondly, the trend of New Public Management (NPM), that takes inspiration from the private sector, promotes increased use of market mechanisms and measurement of financial and operational performance (Hood, 1995; Kraus and Lindholm, 2010). Hence, there are two somewhat contradictory trends at work where cooperation reduce the importance of organizational boundaries while NPM increase the need for delimited organizations for performance measurement (Hodges and Mellett, 1999; Lindberg and Blomgren, 2009; Kraus and Lindholm, 2010). Both of these trends impact control within and across organizational borders in industries such as the healthcare industry (Öhrming, 2008). They are also mirrored in the existing research.

Moreover, NPM has promoted the outsourcing of public sector services to the private sector, to complement the traditionally large public organizations with smaller, more efficient and change responsive private actors (Andon, 2012; Kraus and Lindholm, 2010, Lambert and Lapsley, 2006). A specific organizational structure that has spread across geographies in the wake of the NPM movement is the so called public-private partnership[1] (PPP). As the construction of PPPs have proliferated, a body of accounting and control literature focused on PPPs has also emerged (Andon, 2012).

1 PPPs are developed from the UK Private Financing Initiative (PFI) that was launched in the early 1990s. As a result, PFI and PPPs are commonly used as identical terms (Lambert and Lapsley, 2006).

2.2 Accounting and control in public-private partnerships – previous research

Introducing PPPs

PPPs are the type of inter-organizational relationship most applicable to our study as it corresponds to a more long-term contractual agreement between a private actor delivering services to the public sector. According to Broadbent and Guthrie (2008), PPPs can be undertaken in particular projects within local or central government. Instead of taking over the whole of a public sector operation, it operates "on a particular organizational level while, in other operational units, provision is delivered in full by the public provider" (Broadbent and Guthrie, 2008). Hence, in PPPs the public government function retains the overall responsibility for service provision, and a framework contract outlines the basic responsibilities and rules of the partnership (Kraus and Lindholm, 2010). A stream of regular payments from the public sector reimburses the private actor for its service provision (Lambert and Lapsley, 2006). Often, the relationship is more relational and characterized by direct control than in a traditional arms-length outsourcing contract (Broadbent and Laughlin, 2003, as cited in Andon, 2012; Lambert and Lapsley, 2006). In addition, Broadbent and Guthrie (2008) observed that although the services are said to be delivered in a partnership, in practice they rather take the form of public procurement contracts funded by tax revenues. In this setting, governments move from being service providers to being regulators and procurers of public sector services (Edwards and Shaoul, 2003). At the same time, the partnership aspect remains through a need for the two partners to cooperate and control tasks across organizational borders.

It should be recognized that the PPP literature has experienced several phases and that PPPs may take different forms. Therefore, any consistent definition of what a PPP implies does not exist (Andon, 2012). PPPs encompass procurement of infrastructure or services (Reeves, 2008). Moreover, contract lengths vary, but may extend as long as to 30 years (Reeves, 2008). In its first phase, until the early 90s, it was mostly seen as a method for achieving off-balance sheet financing (Andon, 2012). Following that, it developed into treating how increased efficiency is achieved through competitive tendering, private involvement and maximum risk transfers. Today, the PPP concept has been broadened even further to include wider range of issues (Andon, 2012).

Previous research on PPPs

Lambert and Lapsley (2006) and Andon (2012) reviewed research on PPPs and found that accounting research has centered on the details and mechanisms of PPPs. Andon (2012) concluded that previous research has centered around five major themes (developed from Broadbent and Laughlin, 1999, 2004): the nature and rationale for PPPs, processes and procedures aiding decision to undertake PPPs, processes and procedures for ex-post evaluation of PPPs, the merit and worth of PPPs and regulation and guidance. Moreover, studies are characterized by a focus on accounting calculations for valuation, risk management, accounting disclosure, and public accountability mechanisms (Lambert and Lapsley, 2006). In addition, research has centered on procurement related issues or the early outcomes of PPPs. Hence, research has concentrated more on PPP policy, the contract as such and related technicalities,

rather than producing case studies on how PPPs are operationalized and how accounting and controls are used continuously on day-to-day level (Andon, 2012). Moreover, Andon (2012) concludes that although case studies have been a popular research approach, these been performed at a distance from the actual operation and people engaged.

Against this background, further research that looks beyond the "technicalities" of partnerships is advocated (Andon, 2012). In addition, Andon (2012) states that there is a need for research using case studies with a more practical orientation, examining "detailed performance of work, paying attention to the lived roles and effects". In such studies a relevant study topic would also be the interplay between accounting techniques and "a range of actions, interests, social processes and meanings that frame and affect tasks beyond the financial" (Andon, 2012).

Secondly, previous research has generally treated PPPs as a dyadic inter-organizational relationship, although they are often embedded in a larger context of public sector organizations. Hence, there is room for further exploration of inter-organizational control in PPPs that involve relationships between several organizational units.

A further research gap identified regards the contradictions between the contractual governance and need for cooperation that simultaneously characterize PPPs (Broadbent, 2003, cited in Andon, 2012; Edwards and Shaoul, 2003; Reeves, 2008). As Broadbent et al. (2003, cited in Andon, 2012) see cooperation as central success factor for PPPs in the longer term, the authors advocate less reliance on contractual form and a more relational and trust-built approach. This is in line with the findings of Dekker (2004), studying inter-organizational control in the private sector. He promotes the role of previous relationship and trust building as ex-ante and ex-post forms of informal control mechanisms to be a central complement to administrative control mechanisms. Moreover, Lonsdale (2005, cited in Andon, 2012) argues that making a PPP work in a cooperative and balanced manner involves overcoming significant obstacles such as asymmetric power relations, and imbalances in negotiating available resources and capabilities. However, according to a study by Reeves (2008), cooperative relationships may be developed between contracting partners, while a transactional approach to contract governance is maintained. Evidence on positive effects of cooperation in PPPs is provided in a recent study of five projects by English and Baxter (2010). Firstly, they show how elements of uncertainty, bounded rationality and opportunism were handled, and conclude that contract conditions developed over time in terms of content and form. Uncertainty concerns and change in the projects were increasingly compensated by goodwill trust and relational contracting. Secondly, they show how PPP parties over time re-engaged with less specified and comprehensive contracts, and how parties act in response to changes in the transaction environment. Their findings conclude that PPP contracting is characterized by an ongoing, organic and more "elastic" process than has previously been depicted in existing literature (English and Baxter, 2010). Hence, results from studies examining the role of relational and trust aspects of PPPs diverge. Its role in practice is more complex and influenced by various situational factors, than what theory infers (Andon, 2012). Against this background, there is a need to include informal controls, in addition to administrative, when studying PPPs and to further investigate how contractual governance and informal controls complement each other in achieving cooperative and functioning PPPs.

Fourth, Andon (2012) brings up internationalizing knowledge on PPPs as an additional theme of required research. In previous research there is strong focus on PPPs in the UK and the rest of the English-speaking world, whereas the international perspective has largely been ignored (Broadbent and Laughlin, 2004; Grimsey and Lewis, 2004, as cited in Andon, 2012). In fact only, 7 percent of the reviewed literature by Andon (2012) were based on empirics from outside the Anglo-Saxon jurisdictions. Although PPPs are more common in certain regions of the world, different forms of PPPs still exist in many countries globally (Broadbent and Laughlin, 2004; Grimsey and Lewis, 2004, as cited in Andon, 2012). Hence, there is a need to complement the existing research body with international uses of PPPs, to be able to compare and contrast accounting use in PPP policies and practices between countries and their different jurisdiction, political situations and institutions (Andon, 2012).

In summary, several research gaps have been identified in the current PPP literature. These include the ongoing use of controls in PPPs, further exploration of inter-organizational controls in PPPs that involve relationships between several organizational units, the contradictions between the contractual governance and need for cooperation and lastly internationalizing the current knowledge on PPPs.

2.3 A broader approach to control

2.3.1 The healthcare setting requires a broader approach to control

In order to examine how control is used in the ongoing operations in healthcare delivery, it is important to recognize the specific characteristics of the healthcare sector and the potential impacts on control. Such traits include strong professions along with a dominant focus on what is best for the patient (Lindberg and Blomgren, 2009; Kraus and Lindholm, 2010).

In order to properly depict and analyze the relevant control mechanisms within the setting of specialized healthcare, we will apply the framework by Hopwood (1974). It is chosen as it suits the focus on control in ongoing operations. The framework takes a broader approach to control as it encompasses three different types of controls: administrative-, social- and self controls. A broad conceptualization of control has been advocated by several researchers (Hopwood, 1974; Caglio and Ditillo, 2008; Van der Meer-Kooistra and Scapens, 2008). Furthermore, the Hopwood's (1974) framework has in previous studies proven relevant to use when extended into the inter-organizational setting (Kraus, 2007; Carlsson-Wall et al., 2011).

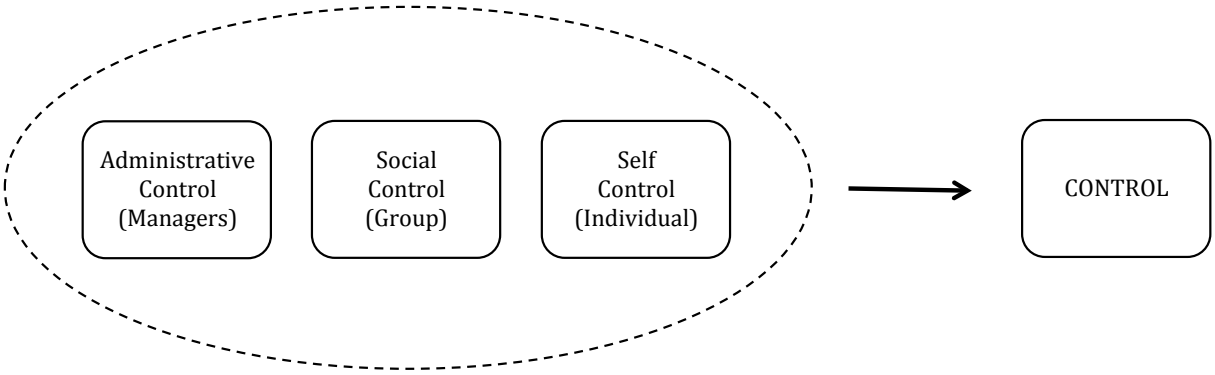

Figure 1. Hopwood's (1974) model of control

Previous research work on PPPs, as well as on inter-organizational controls in the private sector, have been dominated by a focus on administrative controls (Carlsson-Wall, et al., 2011). Administrative controls are implemented by managers as a way to influence the behavior of employees (Hopwood, 1974, ch. 2). It encompasses formal control (rules, standard procedures, budgets, plans etc.) as well as more subtle types of managerial controls (recruitment policies, training, channels of communication).

Secondly, social controls originate from interaction with fellow workers, group norms and group members' mutual commitment. As expressed by Hopwood (1974) such control may encompass group norms about levels of work performance, standards of mutual help, sharing of valued resources and informal guidelines about relationships with other groups. Hence, groups develop a social consensus about what is considered good conduct and acceptable performance. It should also be noticed that managers' efforts to create a common culture are excluded from the category of social controls.

Thirdly, self controls originate from personal values, views and needs, and correspond to an individual's integrity, approach to the role as a professional and private motivations (Hopwood, 1974). In short, self controls define how one would like to act following ones own gut feeling. Such personal values and goals may conflict with administrative or social controls, which can cause anxiety and reduce the effects of such external control (Hopwood, 1974). This was exemplified by the Jones and Dewing's (1997) study on an acute hospital in the UK, where hospital reforms encountered difficulties due to the personal goals and values of employees.

Moreover, according to Hopwood (1974), control consists of interplay between the three influences (i.e. administrative-, social- and self controls) as simultaneously competing pressures. These different influences on behavior may coincide to varying degrees, however, they may also act as contradictory control impulses. Hence, all three aspects of control need to be analyzed separately as well as together (Hopwood, 1974).

In summary, the depicted framework is suitable when examining control in human service organizations (Kraus, 2007). Other values than solely financial, as well as strong professions, characterize this sector and make it relevant to look beyond the traditional focus on managerial

control. It is also beneficial when trying to understand the mechanisms of control in daily operations as managerial control, social norms and own values all influence the actions of humans (Hopwood, 1974). In fact, Kraus (2007) and Carlsson-Wall et al. (2011) found that Hopwood's (2011) broad conceptualization of control was central for their analysis of an inter-organizational control in elderly care as administrative-, social- and self control all played important roles.

The role of strong professions in healthcare

As previously mentioned there are specific characteristic of the public healthcare sector that is believed to impact accounting and control. Central such traits are the strong professions along with dominant focus on what is best for the patient (Kraus and Lindholm, 2010; Lindberg and Blomgren, 2009). These traits can be viewed as influential sources of social- and self controls. As expressed by Kraus and Lindholm (2010): "in the medical profession, it is not considered to be acceptable or legitimate to make decisions that negatively affect people's health on the basis of financial considerations". Within in healthcare, there is also a distinct professional hierarchy and division of labor, where doctors, nurses and assistant nurses perform different tasks. In addition, other professional groups such as administrators and accountants operate as support functions.

The existence of both healthcare personnel and administrative staff results in a balance and prioritization between "costing and caring", and may cause a conflict between administrative control systems and professional values (Kraus and Lindholm, 2010). Liff and Andersson (2011), however, show that such a conflict does not necessarily arise based on professional belongings. When studying three Swedish child- and adolescent psychiatric care units (CAPs) that need to collaborate with other organizations in their operations, they find that care professions inside the units adapted to new NPM-related principles of "customized care"[2] and integrated with the administrative personnel. In contrast, in the inter-organizational context the units resisted cooperating according to the customized care principles. Hence, it is demonstrated that professions choose different operational strategies contingent on the social context, and that the social setting is central in order to understand the professions' impulses to integrate or not (Liff and Andersson, 2011).

To summarize, as typical healthcare characteristics and norms, the role of professional membership in creating social control and the potential conflict between managerial and professional control will be included in our thesis as forces of social controls.

2.4 The concept of control problems

The above framework by Hopwood's (1974) outlines three types of controls. However, it does not include a dimension for explaining why the controls are used. In order to find such a theoretical dimension the control problems of appropriation concerns and coordination requirements, outlined by Dekker (2004), are brought in as useful complementing concepts from the overall inter-organizational control research. A description of the two control problems follow below.

[2] Customized care imply that professions within the same as well as different organizations should cooperate using their unique competences as a means to create more customized and client-oriented care (Liff and Andersson, 2011).

2.4.1 The control problems

Dekker (2004) motivates the inclusion of two control problems by arguing that the control-related research on different approaches to organizing inter-organizational relationships previously has been dominated by a governance perspective stemming from transaction cost economics (TCE) theory. However, a critique by several researchers (Osborn & Hagedoorn, 1997; Dekker 2004) is that TCE and appropriation concerns are lacking to explain the full picture of inter-organizational relationship management and control. Additional important explanatory factor to appropriation concerns include coordination requirements.

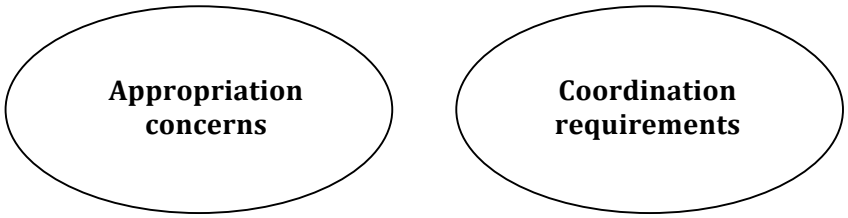

Figure 2. The two control problems outlined by Dekker (2004).

The first control problem of appropriation concerns, imply impulses to safeguard ones investment from being appropriated by the other potentially opportunistic actor in the inter-organizational relationship (Dekker, 2004, 2008). Inter-organizational relationships always have factors of uncertainty regarding future events and behavior, as well as adaptation problems over time as unexpected contingencies arise (Dekker, 2004; Gulati and Singh, 1998). Such uncertainties may involve changes in the market and technological environment, as well as task complexity and unpredictability (Dekker, 2008). Moreover, appropriation concerns originate from contracting problems (Gulati and Singh, 1998). Inter-organizational relationship contracts suffer from bounded rationality issues that limit the possibility to write complete contracts covering every potential future contingency that arise (Dekker, 2004, Gulati and Singh, 1998). As a result of uncertainty and bounded rationality, inter-organizational relationships are governed by incomplete contracts that need to be managed by alternative control mechanisms to the contract itself.

The second control problem involves coordination requirements as inter-organizational relationship actors jointly need to perform value-creating activities to achieve any desired objectives (Dyer & Singh, 1998; Dekker, 2004). Tasks need to be coordinated across the borders of interdependent organizations (Dekker, 2008), and uncertainty is created by anticipation of the extent of ongoing task coordination as well as complexity in decomposing division of tasks (Gulati and Singh, 1998). Furthermore, coordination and joint decision-making requirements increase with higher interdependence and higher uncertainty (Gulati & Singh, 1998).

Gulati and Singh (1998), provide some examples of how different administrative controls may be explained by appropriation concerns and coordination requirements respectively. They relate incentive systems and non-market pricing systems to handling of agency issues (TCE –related)

and managing appropriation concerns. In contrast, they predict command structures and authority systems, standard operating procedures and dispute resolution procedures to be controls that are motivated by coordination requirements (Gulati and Singh, 1998). Such controls give an organizational context that establishes the rules of the game and provide an "administrative architecture" for the partnership (Gulati and Singh, 1998).

Dekker (2004) also argues that trust[3] (a form of social control), originating from previous interaction and other social- and economic embeddedness around the inter-organizational relationship, may mitigate appropriation concerns and coordination requirements. At the same time, such controls are disregarded by traditional TCE (Gulati, 1995; Gulati and Singh, 1998; Dekker, 2004). Examples of social controls that may mitigate control problems are informal coordination and monitoring, and high trust levels between actors, reciprocity norms, reputation and personal relationships (Dyer & Singh, 1998; Dekker, 2004).

Moreover, there has been significant academic discussion regarding if trust (a form of social control) may substitute or complement administrative controls in managing control problems. One can either argue that social controls reduce the need for administrative controls, or alternatively that an increase in trust or administrative control simply increase the overall control (an additive relationship) (Dekker, 2004). It has also been argued that formal controls may increase trust and enhance social control. Dekker (2004) concludes that a wide range of supporting and counterarguments exists, and argues that increasing trust in- and knowledge about a partner can result in either a reduced need for administrative controls or in improved control.

2.5 Derivation of theoretical framework

In the above literature review, we have accounted for existing research on public-private partnerships. In addition, we have brought up important trends affecting inter-organizational relationships in the public sector as well as specific characteristics of the healthcare sector, such as strong professions, with an impact on control. Based on this we conclude the need to apply a broader control framework that also encompasses less tangible types of control, social- and self controls, in the healthcare industry. Lastly, two control problems, from the wider inter-organizational research stream, were accounted for in the form of appropriation concerns and coordination requirements.

2.5.1 The theoretical framework

Based on the literature reviewed above, a framework for analysis is derived to analyze controls in the ongoing healthcare operations in three inter-organizational relationships resulting from one public-private partnership.

The theoretical framework consists of two main concepts: (i) Hopwood's (1974) three types of controls and (ii) Dekker's (2004) two controls problems. The two theoretical concepts are

[3] In this thesis, trust is defined as "a psychological state comprising the intention to accept vulnerability based upon positive expectations of the intentions or behavior of another" (Rousseau, Sitkin, Burt and Camerer, 1998, cited in Dekker, 2004)

combined to suit the investigation of ongoing controls in the healthcare sector and in the inter-organizational setting of PPPs. While Dekker's (2004) control problems of appropriation concerns and coordination requirements explicitly deal with the inter-organizational setting, Hopwood's (1974) administrative-, social- and self controls is originally formulated for an organization's internal controls. Hence, they need to be extended into the inter-organizational setting and adjusted accordingly. Similar extensions of Hopwood's (1974) controls have been done in previous research focused on inter-organizational controls within elderly care (Carlsson-Wall et al., 2011).

Figure 3. The theoretical framework is derived for studying inter-organizational controls in the inter-organizational setting.

Hopwood's (1974) three types of controls in the inter-organizational setting

Firstly, inter-organizational administrative controls are commonly seen as encompassing both outcome- and behavior controls, as well as less conspicuous controls (Kraus, 2007, p. 22). Kraus (2007, p. 24) summarized common inter-organizational controls mentioned in previous research. According to this summary, inter-organizational administrative controls may include outcome controls (measuring, monitoring and rewarding outcome), where joint financial rewards systems and cost estimations are concrete examples. Behavior controls include monitoring and rewards, where concrete examples include standard operating procedures, dispute resolution procedures, planning schemes and quality plans (Kraus, 2007, p. 22, Gulati and Singh, 1998). Lastly, other controls mentioned are joint task groups, alliance boards and meetings. In previous research, using a mix of these controls is advocated (Kraus, 2007, p. 22). Sobrero and Schrader (1998) differentiate between contractual administrative controls and organizational administrative controls. They argue that the contractual control generally provide the frame for aligning partners' incentives in an inter-organizational relationship. On the contrary, organizational controls aims to align common processes and procedures (Sobrero & Schrader, 1998). Similarly to Kraus (2007) and Carlsson-Wall et al. (2011), administrative inter-organizational controls will in this thesis be defined as the joint attempts by which managers from the County, HealthcorpSub, orthopedic clinic at Largehospital and medicine clinic at Smallhospital try to influence the premises that underlie the behavior of their employees in the three inter-organizational relationships.

Secondly, in contrast to administrative controls, social controls emerge through the informal interaction between groups of individuals (Hopwood, 1974) and may also involve informal guidelines about relationships with other groups. In this thesis, the central groups of individuals, for which it is relevant to consider social controls, are the organizations involved in the three inter-organizational relationships of the PPP. Hence, in our thesis inter-organizational social controls will be defined as norms and guidelines on how to interact and relate with one another,

that are developed between the employees at County Management, HealthcorpSub, Largehospital orthopedic clinic and Smallhospital medicine clinic in the ongoing operation and cooperation between the organizations. Hence, inter-organizational social controls are considered laterally between the different organizations' employees in this study. Moreover, due to the lateral approach the managers of the different organizations are also considered to be a part of the group of employees encompassed by social controls. This application of Hopwood's (1974) social controls in the inter-organizational setting differs from Carlsson-Wall et al. (2011) and Kraus (2007), who discussed social controls between different occupational groups in an inter-organizational relationship in elderly care, and where managers were not encompassed.

Furthermore, several researchers including Gulati and Singh (1998) and Dekker (2004) have mentioned trust as a central social control in inter-organizational relationships. Trust building works both ex-ante and ex-post. Ex-ante trust for an inter-organizational relationship actor can emerge based on interaction, reputation or social networks, from which goodwill or trust in capabilities develops (Dekker, 2004). Goodwill trust basically means that an inter-organizational relationship partner is not expected to act opportunistically, but rather act in the interest of the relationship even if it is not in that partner's interest (Dekker, 2004). Capability trust refers to when satisfactory performance is expected by an inter-organizational relationship partner. Moreover, trust may be built ex-post from risk taking, joint decision-making and problem solving, and partner development (Dekker, 2004).
Close interaction results in commitment to- and interest in the outcomes of the relationship, decreasing likelihood of opportunistic behavior and better recognition of it when it occurs (Saxton, 1997). According to the study Gulati and Singh (1998), a prior history between actors matter in terms of increased trust and reduced use of administrative controls.

Thirdly, Hopwood's self controls are included in the framework. These are related to individuals' own goals, values and needs, which influence employee behavior and thereby indirectly impact inter-organizational control dynamics. Aspects of self controls that are relevant to the inter-organizational setting are included in the study. However, since self controls are not direct inter-organizational controls, as they stem from the individual, they are simply included as "self controls" in figure 4 below.

Combining Hopwood's (1974) controls and Dekker's (2004) control problems

As a means to gain further understanding of the use of inter-organizational controls, Dekker's (2004) control problems of appropriation concerns and coordination requirements are added to Hopwood's (1974) controls in the framework. As a result, a theoretical dimension is added that may explain the use of inter-organizational administrative-, social- and self controls. Since the concepts of appropriation concerns and coordination requirements originally deal with the inter-organizational setting, Dekker's (2004) original definitions outlined in section 2.4.1 will be applied in the thesis.

Figure 4 below illustrates the theoretical framework including Hopwood's (1974) three types of controls, extended to the inter-organizational setting, and Dekker's (2004) two control problems.

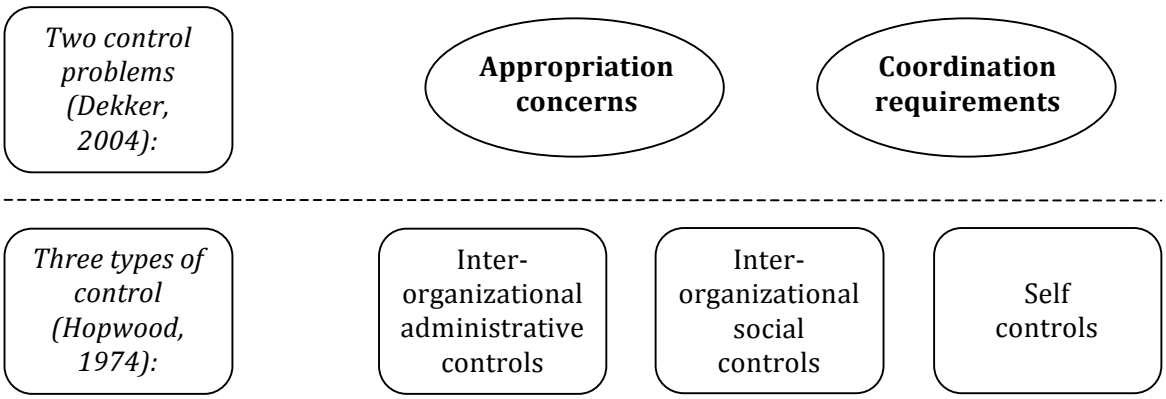

Figure 4. The theoretical framework applied consists of (i) Hopwood's (1974) three types of controls complemented by (ii) Dekker's (2004) control problems of appropriation concerns and coordination requirements.

The following case analysis section is structured to provide an analysis of the empirics using the extended version of Hopwood's (1974) administrative- social- and self controls. In a second step, the use of inter-organizational controls will be related to the concepts of appropriation concerns and coordination requirement. This second analysis is performed in the discussion part, as it implies an additional level of analysis that builds on the case analysis.

3. Method

In this section, the research methodology applied in the thesis is presented and motivated.

3.1 Research design

3.1.1 Empirical method – an in-depth qualitative case study

In order to investigate and answer the research questions posed, an in-depth qualitative case study was chosen as empirical method. This choice was made due to several reasons.

To begin with, previous research on the specific topic of this study is limited. Control in the ongoing operations of a PPP within healthcare has been scarcely researched. Moreover, including three inter-organizational relationships resulting from one PPP, differs from the typically dyadic approach in PPP research. Therefore, the thesis topic is of explorative nature, for which a qualitative case study is a suitable method (Merriam, 1988, p. 25).

Secondly, research questions focused on explaining "why" or "how" a social phenomenon works are preferably investigated using a case study method (Yin, 2014, p. 10). In this thesis it is investigated how inter-organizational controls are used in our specific setting, and how control problems may explain this use. Hence, our study is more focused on exploration and explanation than on description, making a qualitative case study method an appropriate choice (Otley and Berry, 1994).

Thirdly, Yin (2014, p. 12) argues that a qualitative method is suitable when examining contemporary events, when manipulation of relevant behavior by the researcher is not possible. This corresponds to our thesis where a current real-life situation is explored through interviews with involved individuals. It is far from an experiment in a laboratory, investigating isolated variables that are possible for us as researchers to manipulate. Rather, the use of a qualitative case study enables the thesis to investigate a current phenomenon, in a real-life context where the boundary between phenomenon and context is not entirely evident (Yin, 2014, p. 2). Our study of control in three inter-organizational relationships resulting from the same PPP, is a specific phenomenon that is also highly influenced by its context; specialized healthcare provision in a Swedish county. This is also in line with Dubois and Gadde (2002) who conclude that "the interaction between a phenomenon and its context is best understood through in-depth case studies". In this way, one obtains a more holistic view, deeper insights and better understanding of the case studied (Andersen, 1998, p.31; Yin, 2014, p. 4; Merriam, p. 25).

Fourth, doing a qualitative case study enables investigation of human and social behavior (Merriam, 1988, p. 26). It allows for insights into the inner experience of participants and determination of how meanings are formed through and in culture (Corbin & Strauss, 2008, p.12). The case study research design allows for a broad approach to control to be taken in the thesis, in

order to understand how control works in the actual daily healthcare operations. Less tangible dynamics of social- and self controls could be included, to better understand how individuals behave as a result of different control impulses. In short, it made it possible to also study complex social phenomena (Yin, 2014, p. 4).

Lastly, a single case study was chosen instead of a multiple case study design. This is despite the fact that multiple case studies by many are argued to be more appropriate for theory building and generate more generalizable results (Dubois and Gadde, 2014). Against this background, a single case study was still chosen for several reasons. Firstly, the scope of the study is limited, given it being a master thesis. Secondly, according to Yin (2014), doing one in-depth case study allows for handling of several interesting variables and incorporating multiple forms of evidence. This is in line with Andersen who argued that to be able to describe, understand and explain what happens within the organizations, it is necessary to have a large sample of variables but limit the amount of units observed (Andersen, 1998, p.129). Moreover, Dyer and Wilking (1991, cited in Dubois and Gadde, 2014), advocate single case studies arguing that "better stories rather than better constructs" are needed. Further, Dubois and Gadde (2002) state that when the study involves interdependent variables in complex structures, deeper investigation of one case benefit research more than performing numerous case studies.

3.1.2 The research approach - systematic ordering

An important approach in our research is systematic ordering (Dubois and Gadde, 2002). When performing our study we employed an iterative process of continuously, and in parallel, revising theory and empirical findings. Thereby, we took an abductive approach implying that the theoretical framework was adjusted and the empirical field of research were developed as the research process progressed (Alvesson and Sköldberg, 1994, p. 42).
Hence, Dubois and Gadde's (2002) research process of "matching" was applied, as theory was built in a "frequent overlap of data analysis with data collection" (Eisenhardt, 1989).

Such an approach implies that the case study method becomes a rather nonlinear process. The logic behind this approach is that empirical findings may generate unexpected but related results (Dubois and Gadde, 2002). Such results may be interesting to investigate further, in any following interviews or other steps in data collection. In turn, unexpected results implies that the original theoretical framework may need to be altered or complemented (Eisenhardt, 1989), also giving the theoretical framework an evolving nature (Dubois and Gadde, 2002).

Our process took a similar journey as we begun by reviewing literature and chose a preliminary theoretical framework as a structure for interview guides. As interviews/data collection proceeded, findings from previous interviews were used to develop interview guides. We also complemented our initial theoretical framework with additional relevant theories, as data were collected and analyzed.

An advantage with this approach is that it allows for the researchers to fully exploit the nature of case study research as it facilitates deeper insights from the empirical material and the specific context. In line with previous research (Dubois and Gadde, 2014), we needed to adjust the

boundaries of the case study as it proceeded and a clearer picture of the empirical findings unfolded.

3.1.3 Selection of the case study object

An important part of theory building is selecting the case to be studied (Eisenhard, 1989). To operationalize the aim of the study, case organizations in the required form were needed, i.e. a public-private partnership (PPP). Moreover, a certain degree of inter-relatedness and ongoing cooperation was searched for in order for a case study on ongoing control in a PPP to be possible. After having identified a relevant PPP within the healthcare sector in Sweden, the actual inter-organizational relationship between the public counterpart and the private counterpart was concluded to be more complex than solely involving interaction between two organizational units. On the public side of the partnership, a number of organizational units were involved with the private healthcare provider, including other clinics at the same hospital and a similarly specialized clinic at a geographically proximate and larger hospital. Moreover, the public contractual part in this case, the County Management (the regional governance body), was also relevant to include as it continuously interacts with the private counterpart. Hence, it was decided to include three inter-organizational relationships stemming from one PPP in the case study, to better reflect the natural and more complex embeddedness of PPPs in existing infrastructure for public service provision.

However, extending the scope to studying three inter-organizational relationships also meant that a multiple case study approach became out of scope. Instead, the thesis focused on achieving a deeper understanding of one PPP, and the resulting inter-organizational controls used in several inter-organizational relationships.

3.2 Data collection

3.2.1 Primary data

According to Yin (2014, p. 110), interviews are one of the most important sources of case study evidence. Interviews were also the main source of primary data collection in this study.

In total, 22 semi-structured interviews were carried out during February and March 2014, lasting for 45 to 75 minutes[4]. Interviewees were identified gradually, starting from the initial contact at the County Management and onwards through the main contacts established at the different organizations. Moreover, interviewees were selected to cover the four organizational units in the study, but where the respective number of interviews depended on the extent and frequency of daily interaction between employees in the inter-organizational relationship. As focal organization, involved in all three inter-organizational relationships in the PPP, more interviews were for example done with employees at HealthcorpSub.

Interviews were carried out until the researchers perceived the information gathered to be saturated, meaning that additional interviews would not have provided further insights

[4] See Appendix 1 for a complete list of the interviews, detailing interview dates and the titles of interviewees

(Eisenhardt, 1989). All interviews, with one exception, were recorded and transcribed in their entirety to facilitate objective data interpretation and a thorough analysis.

The interviews were carried out in a semi-structured manner, based on guidance from Andersen (1998, p.161-178) on how to structure and execute case study interviews. The semi-structured form was considered suitable as they combine structure with openness for new information and insights, in contrast to surveys or unstructured interviews. Hence, a basic interview guide was prepared before the interview, which provided the interview session with an overall structure, and ensured coverage of the preliminary theoretical framework. Interviewees were, however, given room to expand on topics that provided new information and insights. As new empirical findings were collected, the interview guides were adjusted to suit any new empirical themes or theoretical concepts added along the way.

The interviewees were informed about the general study topic and aim via e-mail or phone as the interviews were booked. In order to make interviewees feel comfortable in the interview setting, the interview was then performed in a conversational manner and each meeting was started off by small talk and information about the purpose of the study. The interviewees were also informed about the anonymization of the study. Moreover, the interviews were conducted in Swedish, as this is the mother tongue of both the interviewees and researchers, to achieve a more comfortable atmosphere and allow for more detail and natural expression. With two exceptions only, the researchers jointly attended all interviews and took turns in asking questions and taking a more observing role while taking notes. Such a method, allowed us better observe tacit expressions such as body language and provided dual impressions and interpretations from all interviews. Following approval from the interviewee, each interview was also recorded. Thereby, the interpretation and impressions of both researchers, as well as notes and the recorded interview, could be compared and discussed after the interviews (Eisenhardt, 1989). The described approach is in line with recommendations by Andersen (1998, p.161-178) and Yin (2014, p. 71-99).

Lastly, some direct observations were allowed for in connection to the interviews. As an example, the researchers were shown lean boards placed in clinic corridors, and observed a daily coffee break.

3.2.2 Secondary data

Although this thesis is primarily based on primary data from interviews, some secondary data were collected and analyzed as support. Firstly, publicly available information such as the procurement contract, annual reports and website information was collected and used as a background information and as a basis for interview questions. Secondly, we have also collected some internal materials including business plans and internal presentation material. Yin (2014, p. 45) and Eisenhardt (1989) both suggest that quality of research is improved when several kinds of data are collected, as it enables triangulation and stronger substantiation of constructs.

3.3 Data analysis

As previously mentioned, the analysis process was initiated while data was still being collected. The main points for such analysis and evaluation, took place in between the three rounds of interviews. As a result of this evaluation, interview guides were calibrated and emerging themes identified.

To facilitate the analytic work the interviews were transcribed and entered into the program Nvivo, in which the documents could be collected, organized and coded according to themes. In addition, all transcribed interviews were printed out on 224 pages and read through by the researchers. This was an important process to become closely familiar with the case (Eisenhardt, 1989). Using the printed copies with notes, in combination with Nvivo coding, themes were constructed that corresponded to the main theoretical framework, i.e. Hopwood (1974). Hence, administrative-, social- and self controls were used as main themes. From these overall themes, sub-themes were applied such as "meetings" and "Smallhospital spirit". When identifying the sub-themes, recurrent information and reflections from several interviewees were looked for and taken into consideration before being included in the study. Another aspect considered was the background and role of the interviewees providing the information, in order to detect patterns in the empirical findings. Processing the empirical findings in several ways and in a structured manner was deemed important in order to prevent information-processing bias (Eisenhardt, 1989).

3.4 Research quality

According to Yin (2014, p. 45) four main tests are applied to evaluate the quality of empirical social research, including case study research. These include construct validity, internal validity, external validity and reliability. In this sub-section, the reliability and validity of the thesis is discussed, in order to facilitate assessment of the quality of the study by readers.

3.4.1 The validity of the study

According to Wilson (2010, p. 199) validity concerns if a study is measuring what it intends to measure. Construct validity refers to "identifying the correct operational measures for the concepts being studied" (Yin, 2014, p. 46). In order to achieve such validity the interview questions used were based on relevant literature, i.e. Hopwood's (1974) control framework (Wilson, 2010, p.120). In addition, the questions were tested in the first round of interviews, after which they were adjusted to become clearer and more relevant (Wilson, 2010, p.120). Some additional adjustments were also made following the second round of interviews. Yin (2014) and Wilson (2010), further point to triangulation as way to increase construct validity. In line with this, secondary data was collected as a complement to the primary data of interviews. The various secondary material collected allowed us to construct interview questions that were more relevant and exact. Moreover, it allowed for a certain degree of cross-checking of information that emerged from interviews.

Internal validity regards the degree to which ones results is coherent with reality (Merriam, 1988, p.177). According to Wilson (2010, p. 119), internal validity regards (i) to what degree an instrument measures what it is supposed to measure and (ii) that the measure encompass all

relevant areas of the study. Yin (2014, p. 45) states that internal validity is achieved through careful analysis of data. To improve internal validity, data analysis was done by matching empirically observed events with theoretically predicted events (pattern matching). As mentioned above, we also took an iterative approach to explanation building, by continuously comparing theoretical predictions with actual case findings, and thereafter revising the theoretical framework used for analysis. These two methods for data analysis, pattern matching and explanation building, are outlined by Yin (2014, ch. 5) as concrete actions to increase internal validity.

External validity refers to the degree to which the results of a study are applicable in other situations than the one studied, i.e. to what degree can results be generalized (Merriam, 1988, p.183.) However, this is more important for studies that are actually aiming to generalize results (Wilson, 2014, p.121; Merriam, 1988, p.184). With its case study research design, this thesis rather intends to explain a particular and context-specific case, which in a later stage may be built on by further studies that aim to test if results can be generalized (Wilson, 2010, p. 121).

3.4.2 The reliability of the study

According to Yin (2014, p. 46) reliability refers to "demonstrating that the operations of a study – such as the data collection – can be repeated with the same results". In order to minimize bias and errors in the thesis, several measures were taken during the data collection phase. Firstly, interview recordings, corresponding transcriptions, interview notes and secondary data were saved and structured into digital folders. A list of all interviewees, their position as well as the time and place for each interview was created in excel. As a result, a digital database was set up containing all material collected. Yin (2014, p. 49) argues that such a systematic and detailed documentation enhances the reliability of the study.

4. Case Analysis

In the case analysis we will firstly introduce the focal organization of this study, HealthcorpSub, and its context. Secondly, a brief insight is given into HealthcorpSub's internal controls. Against that background, the use of administrative-, social- and self controls in HealthcorpSub's three main inter-organizational relationships is accounted for.

4.1 Introduction to HealthcorpSub

In this section we will first shortly introduce HealthcorpSub and Healthcorp Group. Secondly, the procured contract, which sets the context for most of HealthcorpSub's business, is accounted for. Thirdly, we introduce HealthcorpSub's three main inter-organizational relationships, which constitute the focus of this thesis.

4.1.1 Healthcorp and HealthcorpSub

Healthcorp is one of the larger private providers of healthcare and care services in the Nordic region. Healthcorp is fully owned by a private company with the key objective to generate an attractive long-term total return. Healthcorp's strategy to accomplish this is to deliver high-quality and cost efficient services.

HealthcorpSub is a regional sub-unit within Healthcorp's specialized healthcare business area. HealthcorpSub is located, and carry out all its services, at Smallhospital. The unit provides planned orthopedic surgery, mainly hip-, knee- and foot surgeries. However, operations also include general surgery, post-surgery care as well as operating the anesthesia care at Smallhospital. Henceforth, HealthcorpSub will refer to the core activities of orthopedic care only, as the other activities are excluded from this thesis. All HealthcorpSub's operations are located at Smallhospital, a local public hospital in Niceville County. Although HealthcorpSub do some surgery on patients from other Swedish counties, the bulk of patients live within the Niceville County where HealthcorpSub is located.

The Healthcorp Group Headquarter, based in Stockholm, sets the main targets for HealthcorpSub and is involved in major financial decisions, such as larger procurement offers or investments.

4.1.2 HealthcorpSub's contract with Niceville County

The company that is now known as HealthcorpSub was established in Niceville 2009 as a result of a public procurement, made by the Niceville County. The winner of the procurement was a competitor to Healthcorp, which took over some specialized care clinics that had previously been run by Niceville County, as well as the personnel and a rental contract to the premises at Smallhospital. In 2011 Healthcorp Group acquired the competitor, including the contract, and HealthcorpSub became a subsidiary to Healthcorp.

The contract for the procured services is a five-year contract, with an option to twice prolong the contract with two years. Niceville County recently decided to prolong the contract with two years until 2016. Following this period, the contract may be prolonged with an additional two years without a new procurement. However, this is dependent on a political decision in favor in the County, which in turn is likely to depend on the county election outcome in the fall of 2014.

As mentioned above, the contracted services include orthopedic care, some general surgery and post-surgery care as well as operating the anesthesia service at Smallhospital. The contract for orthopedic care, which is the main part of the contract, can be divided into two parts: (i) Taking a "geographic responsibility" for providing general orthopedic care to the population in the west part of Niceville County where Smallhospital is located and (ii) providing some specific types of planned orthopedic surgery for patients referred there from the whole of Niceville County. The regional responsibility is contracted at a fixed, but inflation adjusted price. Pediatric (child) orthopedics and emergency care are excluded from the contract and are provided by the public orthopedic care at Largehospital. The planned orthopedic surgeries are invoiced at a fixed price per type of surgery, but with guaranteed volume or minimum payment per month. As long as HealthcorpSub provides the contracted services to Niceville County, they have the possibility to take on additional planned surgery from other counties in order to fill capacity and increase profit.

4.1.3 HealthcorpSub's inter-organizational relationships

In this section we will introduce HealthcorpSub's three main inter-organizational relationships, which consist the focus of this thesis. These inter-organizational relationships are illustrated in the figure below and presented in text in the same order as outlined in the figure.

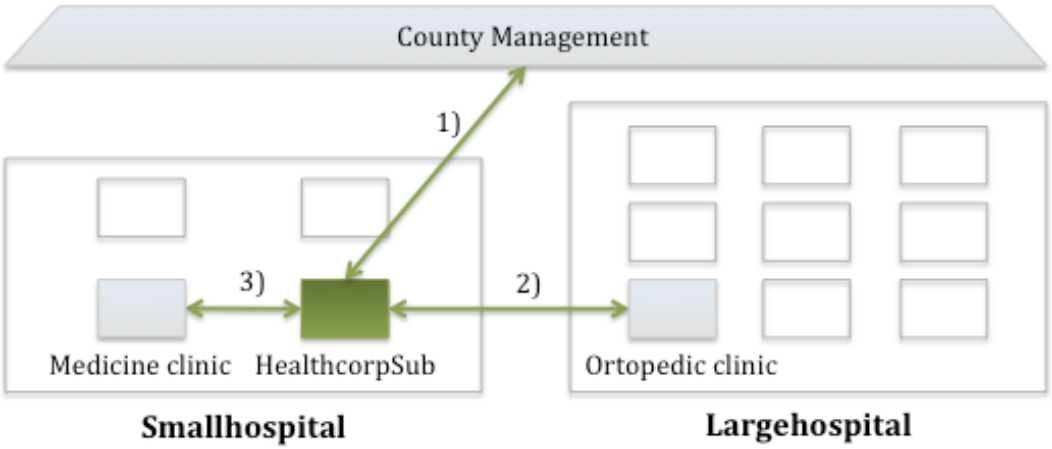

Figure 5. HealthcorpSub's three main inter-organizational relationships.

Firstly, HealthcorpSub has an inter-organizational relationship with the County Management of Niceville County. The County Management is the counterpart for the procured contract, which outlines the main terms for HealthcorpSub's operations. In addition, there is continuous interaction between the parties. For example, many details of the contract have been (re)-negotiated between the management at HealthcorpSub and the County Management after the

actual procurement. Thus, when there are discrepancies regarding the interpretation of the contract, the County Management is HealthcorpSub's counterpart.

Secondly, HealthcorpSub has an inter-organizational relationship with the orthopedic clinic at Largehospital, which is the largest orthopedic clinic in the County. The parties need to collaborate around the flow of various categories of patients. Patients are referred from the orthopedic clinic at Largehospital, as well as from other health providers in the County, to HealthcorpSub for certain kinds of orthopedic surgery. Some orthopedic patients at Smallhospital, in need for emergency care, are also sent in the other direction, from HealthcorpSub to the orthopedic clinic at Largehospital. The decision of which hospital a patient should be sent to is not always easily made. At the same time, the decision is important both from a care perspective and a financial perspective as more complicated or high-risk patients generate higher costs than other patients.

Thirdly, HealthcorpSub has an inter-organizational relationship with the medicine clinic at Smallhospital. Two categories of patients, emergency patients with hip fracture and patients with infections, who get surgery at HealthcorpSub's orthopedic clinic and needs to be admitted to a ward, are placed at the medicine clinic. The orthopedic clinic rents four plus four bed places from the medicine clinic dedicated to such orthopedic patients. These patients are under the medicine clinic's responsibility but HealthcorpSub's doctors are involved in the treatment.

Of course, although not in the scope of this thesis, HealthcorpSub also has to interact with a number of other clinics and organizations. For example HealthcorpSub take on planned surgeries from other counties when there is free capacity. Such incoming patients encompass both public healthcare patients from other counties and patients referred by private insurance companies. Another example of a clinic that HealthcorpSub interacts with is the radiotherapy clinic at Smallhospital.

4.2 HealthcorpSub's internal controls

To understand the use of inter-organizational controls in the PPP, it is valuable to first understand some aspects of how HealthcorpSub is internally managed and controlled, as they consist the private counterpart involved in all three inter-organizational relationships. Therefore, this section provides a background on the internal operational controls before the analysis of inter-organizational controls is commenced in the next chapter.

4.2.1 The use of detailed standards and KPIs

HealthcorpSub aims to provide safe and high quality care as effectively as possible. Careful planning of surgeries and detailed processes is depicted as a key to accomplish such efficiency. HealthcorpSub is particularly able to achieve this due the limited number of surgery types performed, enabling employees to become specialized, detailed processes to be established and economies of scale to be reached. Therefore, standards and work processes are seemingly more detailed than the ones observed in the public clinics in the study.

Similarly, financial as well as non-financial KPIs are more extensively used at HealthcorpSub than in the public clinics in this study. Some quality-related KPIs are even measured on an individual level for doctors, a practice depicted as rather unique within healthcare. The stated purpose is to continuously improve the doctors' performance and surgery results. The extensive use of KPIs is also related to the increased scrutiny faced as private healthcare provider. Essentially, having concrete numbers and measurements to demonstrate, is a management strategy for being able to answer skeptical questions at any time. To do this, HealthcorpSub also aims to be proactive both in communication and documentation.

Four times a year the HealthcorpSub's management meets with each ward/sub-unit and informs the employees about the financial results, budgets and the work with the marketing of HealthcorpSub. The idea with this is to make the employees as engaged as possible in the financial results and the marketing of HealthcorpSub. Financial and non-financial KPIs are communicated to the employees on a monthly basis, as well as communicated on regularly updated "lean boards".

Moreover, Healthcorp's high degree of specialization implies that they are one of the larger units in Sweden within its specialty. As such they aim to regularly produce and publish best practice and scientific research within the field. One of the main strategies for growing profitability is to add surgery volume from other counties, which requires building a brand within its field of specialization. Activities such as the above and publishing of quality KPIs is key to strengthen the brand of HealthcorpSub's orthopedic clinic in the eyes of outsourcing decision makers at orthopedic clinics in other counties.

HealthcorpSub produce a yearly activity report with facts about strategy, operations, financial as well as operational targets and KPIs. The report is more extensive than what is demanded by any external part. The reason for this is that the report is used as information and marketing material and supposed to help communicating the benefits of HealthcorpSub.
Within the County, HealthcorpSub has aimed its marketing towards three interest groups: politicians, purchasers (the County Management) and consumers. In addition to the above communication channels, HealthcorpSub aims to market itself towards these three local interest groups by taking part in local forums. One example is the local business fair, in the city where Smallhospital is located, to inform and market its business. Hence, several forums exist where the organizational units in the inter-organizational relationships meet outside of regular operations.

4.2.2 An active effort is made to implement a unique corporate culture

HealthcorpSub has articulated corporate values called OPEN, which state that the employees should be caring, professional, engaged and innovative. However, few employees spontaneously mention this when asked about corporate values.

The management at HealthcorpSub wants the employees to feel a difference from working in public healthcare. They want employees to feel as a separate, and smaller, organization with the possibility to really affect their work environment as well as the quality and efficiency of HealthcorpSub. The smaller organization and fact that the employees meet someone in the management group on a daily basis implies a great opportunity to affect management decisions.

As expressed by the CEO of HealthcorpSub: *"…one should feel a difference, experience a difference in that one works in a private organization – that something has happened."*

Moreover, to accomplish the feeling of a different organization, HealthcorpSub tries to make the details stand out, including everything from branded pencils to different working clothes. Even though the experience for patients should be a smooth unnoticeable transition between the public units and HealthcorpSub, they still aim to make patients aware of that it is HealthcorpSub that treats them for marketing and branding purposes.

As stated above, the marketing strategy is focused on HealthcorpSub and their services rather than the Healthcorp Group. The same strategy is generally used for employer branding and the management of HealthcorpSub works hard to implement the feeling of HealthcorpSub being a strong team, rather than making the employees identify with the group. As expressed by a Head of Clinic at HealthcorpSub: *"The orthopedic clinic at Smallhospital" is the main brand, a brand built during 15 years and centered on the high competency of the personnel at the clinic."*

In summary, there are aspects in which HealthcorpSub stands out against the public clinics in their internal controls in operations. However, in other ways, ties are still strong to HealthcorpSub's history as a public healthcare provider.

4.3 Administrative control in HealthcorpSub's inter-organizational relationships

In this section we will go through the observed administrative controls in HealthcorpSub's three main inter-organizational relationships one by one.

4.3.1 Administrative control in HealthcorpSub's relationship with the County Management

The contract sets the ground rules for HealthcorpSub's business

The contract procured by Niceville County sets the ground rules for HealthcorpSub's business. The absolute majority of the Company's revenues are negotiated in the contract. Signing the contract from the beginning and changes with high financial impact are handled between he Healthcare Director at the County Management and Healthcorp Group headquarters, however this contact is limited as long as it is business as usual. The Contract Responsible at the County Management and the CEO of HealthcorpSub handle most continuous contract adjustments. However, the Healthcare Director does have yearly follow up meetings with HealthcorpSub's CEO and also take part in the some joint meetings.

The complexity of the services procured by Niceville County from HealthcorpSub has put demands on a more flexible contract than what is usually used when the County procures services. To give a private company full responsibility for serving the population within a certain area (west part of Niceville County) with specialized healthcare is quite unique in Sweden. Thus the initial procurement requirement did not include all the necessary details due to the difficulty of defining them beforehand. Instead these details are negotiated on an ongoing basis as questions about the contract occur in operations. Often contractual changes is suggested by

operating managers based on what they see as more practical solutions, which the Contract Responsible at the County Management and the CEO of Healthcorp then incorporate into the contract.

Regular meetings at different levels are key to make the relationship work

A set of regular meetings at different levels in the organizations is, according to the Healthcare Director, a key function to make the relationship work without a pre-written detailed contract:

First and foremost, we set the structures. Much of the preparatory work was about that... which groups you need to participate in. Since everything is processes, one cannot survive as a separate provider. It is our responsibility to see to that one gets integrated into all groups and understand how it should work"

Most of the meetings were established already before HealthcorpSub's activities became privately run. Thus, Niceville County Management did not have to create new forums but rather make sure that HealthcorpSub was included in all necessary forums. In some cases HealthcorpSub are required by the contract to take part in the meetings. However, since the meetings are for mutual gain, HealthcorpSub voluntarily participate. The most central meetings encountered are listed below:

- *Regional collaboration meetings* for orthopedic specialized care in Niceville County and its two closest counties. Medical treatment standards are discussed and best practices shared in order to ensure equal care for patients in the whole region.
- *Niceville County collaboration meetings* for the three orthopedic clinics in Niceville County. Treatment standards and continuous operational collaboration is discussed.
- *Controller meetings*, where contractual and financial issues related to the procurement contract are discussed between HealthcorpSub's management and the Contract responsible administrator of Niceville County.
- *Inter-clinic improvement group* handling process and routine improvements for the collaboration between HealthcorpSub orthopedic clinic and the Smallhospital medical clinic.
- *Smallhospital forum* discussing hospital wide strategy and marketing issues in a workshop like forum, sometimes together with other interest groups
- *Real estate committee* handling rental, investments in common facilities and renovation.
- *Private healthcare industry forum in Niceville County*. Private healthcare actors discuss their common commercial and operational interests together with the Healthcare director.

The referral handling in the County is largely centralized

A central infrastructure for the services purchased by Niceville County from HealthcorpSub, worth mentioning is. As stated above HealthcorpSub are responsible for providing some specific kinds of "planned orthopedic surgery" for patients referred there from the whole of Niceville County. The planned orthopedic surgeries are invoiced at a fixed price per type of surgery, but with a guaranteed volume or minimum payment per month. Due to this contractual feature, there is an incentive for the County and the public healthcare units to send enough patients to HealthcorpSub to reach the guaranteed volume each month.

In order to achieve this and control the referral flow, a dedicated referral-responsible administrative employee sorts most referrals manually in the electronic patient medical record system Cosmic. Referrals sorted to HealthcorpSub are then sent to them in within Cosmic. Thereby, Niceville County retains a rather one-sided responsibility for the flow of referrals and assortment process, where HealthcorpSub has little interaction or possibility to affect the volumes sent. It has happened that Niceville County has contacted HealthcorpSub and asked to change some of the volume from for example hip surgery to knee surgery. From the beginning there was a problem with that HealthcorpSub received patients that had already been on the waiting list for so long that they had problem to do the surgery within the guaranteed 90 days. However, this was discussed during Niceville County collaboration meetings and was adjusted in the contract so that only patients that have been waiting shorter than 9 days can be sent to HealthcorpSub as contracted volume. The other patients Niceville County generally send to other private healthcare providers or to Healthcorp for a separately negotiated price for these patients and with separately specified deadline.

Some selected KPIs have to be reported and there are few goal-related incentives

In the contract it is stated that HealthcorpSub has to report some quality related KPIs and report numbers to the Swedish national Open Comparisons. For customer satisfaction and availability a certain minimum level has to be reached for part of the payment to be done. However, the other KPIs just have to be reported and no demands or incentives are connected to the result.

In summary, several administrative controls are used in HealthcorpSub's relationship with the County Management. A main function of HealthcorpSub's inter-organizational relationship with the County Management is to set and continuously develop the administrative controls for the entire PPP. To negotiate contract, set meting structure, referral handling structure and reporting standards. The contract and the meeting structure are the most central administrative controls in the relationship between HealthcorpSub and the County Management. The contract is written in quite general terms, which implies flexibility in operations, but also need to continuously add details when ambiguities occur.

4.3.2 Administrative control in HealthcorpSub's relationship with the Largehospital orthopedic clinic

There are two main issues that the collaboration between HealthcorpSub and Largehospital orthopedic clinic aims to handle. Firstly, referrals should be sent to the right place. Secondly pre-arrival information about emergency patients that are sent from Smallhospital to the Largehospital orthopedic clinic needs to be communicated as well as possible.

The strategy from the County Management with regards to where patients should be sent is clear and most interviewees agree that in reality it is quite simple to say which clinic a patient should be sent to. As described above the majority of referrals are sorter centrally. However, decisions are sometimes taken by the treating doctors, where practices maybe less consistent. In addition, there are naturally emergency situations in which communication and coordination between the two clinics are necessary.

There are cases where the patient flow do not end up as planned, mainly following incorrect referrals by doctors. The Referral Responsible explains how this happens at Largehospital: *"Some employees says: 'I do not think this system is so good, I want to cure these patients myself'. But if the decision is taken that a certain patient group should be sent to HealthcorpSub, then there is not personnel or beds for this group [at Largehospital]."* Moreover, personnel at Largehospital experience that patients from HealthcorpSub sometimes are sent to them too easily, exemplified by this quote by a doctor at Largehospital: *"Sometimes patients are sent to us before they have made sure it is us who should treat the patient. In that case they might do it because a out-patient visit (physical examination) is not as profitable as a surgery."*

Regarding more unique cases where the contract does not specify where a patient should be treated, the managers of the respective orthopedic clinic may just simply call each other and agree how to handle the specific situation at hand. In emergency situations the communication is done between the individual doctors in duty, exemplified by a Largehospital employee*: "In emergency situations, when one has got patients in Smallhospital that is supposed to have surgery at Largehospital, the ["on call"] Orthopedic surgeons calls Largehospital to communicate what is coming"*. However, a HealthcorpSub employee states that this does not always work seamlessly: *"Then, sometimes they do not want to take the patient…"*.

Many of the operational problems that arise between the orthopedic clinics are handled at Niceville County collaboration meetings. As the contract is written in very general terms, there is seldom need to change the contract when the group at the meetings have come to an agreement of how to handle a problem. When a change in the contract is needed the Niceville County collaboration meetings discuss what the best practical solution is and then propose a change in the Contact to the Responsible at the County Management and the management of HealthcorpSub.

In practice when patients are sent to HealthcorpSub, that the HealthcorpSub employees believe should be treated at Largehospital, they send a new referral to Largehospital. In general, these kinds of situations are not communicated around further. The rather simple decision process and the fact that the financial terms are not discussed between the operational personnel in the Niceville County collaboration meetings imply that most issues can be pragmatically handled. Moreover, it implies that the personnel in both organizations perceive that a solution of mutual gain is generally found.

In summary, the contract is an important administrative control also in this relationship, as it sets the frame for the relationship between HealthcorpSub and the Largehospital orthopedic clinic. Moreover, most issues between the clinics are handled at the Niceville County collaboration meetings. In this setting, the parties discuss operational interpretation of the contract and come up with proposals for changes. However, the actual contractual changes are written by the County Management together with the management of HealthcorpSub.

4.3.3 Administrative control in HealthcorpSub's relationship with the Smallhospital medicine clinic

Emergency patients with hip fractures are treated at HealthcorpSub's orthopedic clinic. When these patients need to be admitted to a ward they are placed at four separate bed places at the

medicine clinic, which has the main responsibility for them. However, as a set routine the orthopedic surgeons from HealthcorpSub perform rounds for these patients together with the medicine clinic doctors.

There are also four additional bed places rented by HealthcorpSub at the medicine clinic for orthopedic patients with infections. Also in this case the medicine clinic have the main responsibility for the patients. HealthcorpSub's orthopedic surgeons perform rounds for theses patients together with nurses from the medicine clinic and act as consultants when questions arise.

The ground rules for this collaboration are set in the procurement contract, and in various small complementing contracts. However, the contract is not detailed enough to encompass the coordination and work practices in daily operations. Instead, such routines and procedures are outlined in memorandums (henceforth memos). The orthopedic doctors, from HealthcorpSub, arrive at the medicine ward at the same time every day and goes trough the orthopedic patients as consultants for the medical doctors. When emergency patients in need for orthopedic care arrives the medicine clinic, personnel calls the orthopedic clinic and schedules the time for delivering the patient for surgery. These kinds of interaction are clearly stated in memos, regularly updated by the medicine clinic management after discussion with HealthcorpSub management. For general improvements in the process with regards to orthopedic patients the manager of the medicine clinic meets with the manager of the orthopedic clinic and the manager of the anesthesiology clinic (both HealthcorpSub) twice a year.

In summary, routines and detailed memos outline the collaboration between the Smallhospital medicine clinic and HealthcorpSub. Inter-clinic improvement group meetings exist even though many issues are handled in sporadic communication, often face-to-face between managers and employees in the ongoing operations.

4.3.4 Summarizing the use of administrative control

The use of administrative controls observed in the three inter-organizational relationships is summarized in the table below.

County Mgmt. - HealthcorpSub	Largehospital orthopedic clinic – HealthcorpSub	Smallhospital medicine clinic – HealthcorpSub
• Contract – Continuous adjustments. Sets ground rules (for all three relationships) Openly written • Meetings infrastructure, participate in some • Centralized referral assortment, implemented by County Mgmt. • Monitoring of the KPIs reported • Some goal-related payments	• Contract – guidance for operations • Niceville County collaboration meeting, where contract is interpreted, necessary changes are discussed and operational issues handled • Sporadic communication between managers to resolve issues (calls and e-mails)	• Contract – guidance for operations • Routines and procedures – outlined in memos • Inter-clinic improvement group meetings • Sporadic communication between managers (face to face and calls)

Table 1. Overview of the main administrative controls in the three inter-organizational relationships studied.

4.4 Social control in HealthcorpSub's inter-organizational relationships

In this section we will go through the observed social controls in HealthcorpSub's three main inter-organizational relationships one by one.

4.4.1 Social control in HealthcorpSub's relationship with the County Management

The management of HealthcorpSub is almost the same as before the unit was privatized. The same applies to most personnel. Thus, the County Management knew that they could manage the operations in a good way before the contract was signed as well as had personal relations to the management. As expressed by the Health Director:

"It was the same employees the first day as a private company as the last day under the County's ownership. This fact made me, and others with me, to feel a great trust in that the day-to-day operations and the genuine and well working unit would remain to work well. So the question is more about management. And when you then choose management that knows the operations well, such as the CEO of HealthcorpSub that had been there for many years. Then of course you feel a much higher level of trust."

The County Management's relationship with Healthcorp's headquarters is described as less trustful as a result of less historical relationships and more harsh and distributive negotiations. The latter described by the Healthcare Director: *"The CEO at the time for the first procurement … had another approach. They like tough negotiations where you cannot just sit and talk. Sleeves are rolled up, power should be demonstrated and threats and all these suppression techniques used."*

The County Management experience that there is a culture to agree between the healthcare actors in the County, to be open-handed in negotiations, rather than hard and distributive, to be able to reach agreements soon. A person in the County Management expresses this as follows: *"I think that everything in Niceville County is affected by this [open-handed approach] … If I compare with Stockholm, where it always have been competition ... It is much harder to establish shared task forces or healthcare programs there, it is another culture."*

The management of HealthcorpSub feels solidarity with Niceville County as previous public employees. The main vision of improving the healthcare within the County without spending too much of the public resources is well aligned with their personal vision. The collaboration with the County Management is described as good and centered around giving each patient the best possible care. A Head of Clinic at HealthcorpSub expressed this as follows: *"We have a good collaboration. In general I think that the patients are in focus and that it is what is most important for us in the long run. We are respected by the County Management and all in all they think we do a good job, even if they do not say it so often."*

However, he does feel that HealthcorpSub despite of this are not treated as equal to the public clinics. This, as well as his care for the taxpayers money, is expressed in the following quote by the HealthcorpSub manager: *"They scrutinize us harder than their own operations and in one way this might be good, it is the taxpayers money, but we think that it could be equal. It is much politics and tactical considerations sometimes, I think" … "They look for the best for their own operation. That we compete for the taxpayers money."*

In summary, a high level of trust, due to the historical collaboration before the privatization, characterizes the social controls in the relationship between HealthcorpSub and the County Management. However, the County Management seems to have some worries with regards to the private ownership of HealthcorpSub. In turn, the management of HealthcorpSub feels more scrutinized than public healthcare clinics.

4.4.2 Social control in HealthcorpSub's relationship with the Largehospital orthopedic clinic

Largehospital and Smallhospital have a long history of competing for the resources in Niceville County. This has resulted in a sense of rivalry between the hospitals. Smallhospital has in many cases lost the battles for resources against Largehospital and have been forced to close down clinics when operations were moved to Largehospital. As a result, the feeling of rivalry seems to be stronger among the employees at Smallhospital than among those at Largehospital. One employee at HealthcorpSub explains the nature of the competition for resources like this: *"I guess it is a little bit in the nature of a University hospital that they always wants to be the largest and have the most tasks."* Or as expressed by a doctor at Smallhospital: *"Largehospital wanted to take over our business and close us down, they did not want us to remain in business. That has been communicated from Largehospital several times. As a Head of Clinic [at Largehospital] put it: Close down the hot dog kiosk [in Swedish Stäng ner korvkiosken]."*

Still, doctors at both hospitals feel that they can call doctors at the other hospital to discuss patients that are sent between them. However, in cases when they do not know each other personally they are hesitant to call if it is not necessary and may in some cases prefer e-mail.

The attitude at Largehospital's orthopedic clinic is also somewhat vigilant against the fact that HealthcorpSub is privately owned. The HealthcorpSub personnel, for natural reasons, are more familiar with the contract and works strictly after the terms. When this leads to that they will not do something they did before the privatization, personnel at Largehospital orthopedic clinic often assume it is for profit reasons and argumentation may arise. This is well described in the following interview sequence with a doctor at HealthcorpSub:

HealthcorpSub doctor: "If someone have a broken a leg [end up at Smallhospital] and it is an orthopedic case and not very advanced the doctors at the Largehospital orthopedic clinic says that we should handle this at Smallhospital, as have always been done. They do not know that our contract says that we should not handle this type of cases. We are not supposed to intramedullary nail femur or tibia (in Swedish märgspika lårben eller underben) for example."

Interviewer: "And what do they answer if you tell them on the phone that this is not in your contract?"

HealthcorpSub doctor: "Then they say: I don't give a shit, our capacity is filled up. And then we sit here with a patient and it is a lot of phone calls and hard feelings and after a while the patient end up at one of the clinics."

Interviewer: And sometimes the patient ends up at HealthcorpSub even though it is not supposed to?

HealthcorpSub doctor: "Yes, sometime here, even though it is not [supposed to]… But as the years have gone by it is getting better. After some time a doctor at the [Largehospital] hand surgery unit starts to understand that we do not handle any hand surgeries here. But is has taken a very very long time."

This kind of problems is handled over time as the personnel at both hospitals learn how things are to be handled. However, some of the unwillingness to take on patients that previously was handled at Smallhospital seems to be linked to a skeptical view on private healthcare. As was expressed in the quote on page 33 where the Largehospital doctor draws the conclusion that HealthcorpSub sent some patients to Largehospital for profit reasons.

In summary, HealthcorpSub and the Largehospital orthopedic clinic have some historical rivalry that characterizes the social controls in the relation. However, after all what is best for the patient is first in mind for the employees at both hospitals. This is always the main argument from both sides in discussions like the examples above. Even though they from time to time do not agree on what this is. Often because of lack of knowledge about each other's premises.

4.4.3 Social control in HealthcorpSub's relationship with the Smallhospital medicine clinic

If the restructuring and saving programs have implied some rivalry between the both hospitals orthopedic clinics, the opposite is true for HealthcorpSub's cooperation with the medicine clinic at the same hospital. The majority of the interviewed at Smallhospital, at all levels, mentioned the "Smallhospital-spirit" when asked about organizational culture. The "Smallhospital-spirit" is not a defined concept but most employees talk about it as an aim to cooperate within the hospital to increase efficiency, save resources, compete with Largehospital and retain operations within the hospital.

The efficiency and flexibility, stemming from the threat of closedown, is emphasized by the following quote from a Head of Clinic at HealthcorpSub: *"Smallhospital have always been under the threat of closedown and if you are threatened you have to be efficient and then you probably also are a bit more open to change … This I think is the Smallhospital-spirit, an openness to change. Maybe this is even more applicable on us [HealthcorpSub] as we have the eyes on us as a private healthcare provider."*

The fact that the Smallhospital medicine clinic and the HealthcorpSub orthopedic clinic are dependent on each other and needs to stand united is further highlighted in the following quote by a doctor at Smallhospital: *"Yes, we are definitely dependent on each other, in both directions. That implies that you do not make too much war at each other as you have to come to an agreement so that things work well so that the front is kept against Largehospital, which of course then is our number one enemy so to say, to use military vocabulary."*

This can be contrasted to Largehospital, where few employees identify with the hospital but rather with their clinic or specialization. As expressed by a doctor at HealthcorpSub: *"A large clinic at Largehospital knows that they will never be closed down. They can argue with other clinics at the hospital, as much as they want, nothing will happen. Here you know that we are bricks that stand by each other to support."*

The fact that HealthcorpSub is a privately owned seems to be less important for the employees at the medicine clinic, than for the employees at Largehospital orthopedic clinic. The fact that there was no big change in operations, rather just a shift in clinic ownership, is more obvious for the personnel within the hospital. Also, few situations of profit or cost split occur in the relationship between the medicine clinic and HealthcorpSub. When considering how issues are handled across organizational boundaries, and given that HealthcorpSub is privately owned, a doctor at the medicine clinic reflects as follows: *"Mediate. When it comes to HealthcorpSub we always try to find a way to compromise. If it is the Largehospital then it is more a language of force…"*

However, some employees at HealthcorpSub feels that the strong connectedness to Smallhospital have decreased as a result of being a separate and private organization. This is expressed as follows by a nurse: *"It feels like HealthcorpSub have been excluded from the Smallhospital-spirit. We are looked upon and scrutinized in a different way than before [the privatization]. I think that the Smallhospital-spirit is important and that we should be part of it even if we are private."*

Finally, one can observe that there is also a social pressure to behave in a way that is accepted within the rather tight community of people that knows each other within the healthcare professions, at Smallhospital and within the small city where Smallhospital is located. This creates a social incentive to act in a responsible way with the best for patients, the Smallhospital and the city where it is located. This implies an additional layer of social control over the HealthcorpSub employees, as well as other Smallhospital employees. This is well described by a new employee at Smallhospital when discussing why he believes that the privatization, in his opinion, have worked well at Smallhospital:

"I think there is both the patient focus and a social… A social network if you express it like that." … "Smallhospital is important for the city [where it is located] and I believe that it would be hard to be the CEO for a privatized clinic and implement economical values and then stand up for these to people in the city, as a colleague,

citizen and neighbor." … "Or to say that we will close this clinic down and send the patients to a clinic in Stockholm because it is profitable."

In summary, the Smallhospital spirit and a culture of collaboration characterize the relationship between HealthcorpSub and the Smallhospital medicine clinic. The private ownership of HealthcorpSub does not seem to affect the social controls in the relationship.

4.4.4 Summarizing the use of social controls

The use of social controls observed in the three inter-organizational relationships is summarized in the table below.

County Mgmt. - HealthcorpSub	**Largehospital orthopedic clinic – HealthcorpSub**	**Smallhospital Medicine clinic – HealthcorpSub**
• Trust – due to history • Culture to reach agreement and find pragmatic solutions • Social controls from time as a public unit is still in place in HealthcorpSub; implies remaining sympathy to for public units • Some distrust towards HealthcorpSub as a private actor, they feel more scrutinized	• Historical rivalry – most prominent among Smallhospital employees → More conflicts, less communication • Some distrust towards HealthcorpSub as a private actor → Largehospital blame the clear-cut task/patient division on HealthcorpSub being private • Patient's best – a shared social control	• Smallhospital spirit – the clinics are dependent on each other's existence • Private ownership is less important than the long relationship between employees • Do not compete for the same revenues and costs, in the same way as HealthcorpSub – Largehospital orthopedic clinic • Community spirit in Smallhospital city

Table 2. Overview of the main social controls in the three inter-organizational relationships studied.

4.5 Self control in HealthcorpSub's inter-organizational relationships

In this section we will go through the observed self controls in HealthcorpSub's three main inter-organizational relationships one by one.

4.5.1 Self controls in HealthcorpSub's relationship with the County Management

HealthcorpSub's management and the County Management worked together, within public healthcare, before the privatization of HealthcorpSub and the personal relationships appear to have been fairly good always. Thus, on a private level, management at both sides of course wants to find ways to reach agreements and keep the personal relationships good.

The involved managers in the relationship between HealthcorpSub and the County also seem to share the personal belief that the most efficient way to manage the relationship is to be open-handed from both sides to make the relationship work well in the long run. This is illustrated in

the following quote by the Contract Responsible at the County when describing a situation where HealthcorpSub had legal right to compensation but agreed not to claim it:

Contract Responsible: "…this was actually a case where they should have received the guaranteed compensation, but we said: you get so high payment for the geographic responsibility, so this time you will not receive the guaranteed compensation. They, accepted this, even though we would not have stood a chance in a legal process."

Interviewer: "So there is some room for…"

Contract Responsible: "For mutual agreements, yes. Just because it is practical."

Interviewer: "Why do you think that HealthcorpSub chose to agree on this?"

Contract Responsible: "They will work together with us for several years. It is in everybody's interest to have a good collaboration."

Management from both organizations expresses that this kind of open-handed approach to the relationship has been dependent on the personality of the involved management. When other persons were involved in the contract discussions these were significantly more harsh and distributive. This is expressed by the Contract Responsible: *"I mean much of this is dependent on which persons that are in this Niceville County collaboration meetings. The first years when we were doing this the orthopedic managers were squabbling all the time. But now these persons have been changed."*

It is noticeable how the self controls of the managers generally seem to be aligned with the social control in the relationship between HealthcorpSub and the County Management, characterized by an agreement culture. This common attitude between County Management and HealthcorpSub management (at a higher hierarchical level) can also be expected to have contributed to setting the social norm of mutual agreement in HealthcorpSub's relationships with the Largehospital orthopedic clinic and the Smallhospital medicine clinic. In short, the self controls of the managers appear to have affected social controls for employees at a lower hierarchical level towards diplomacy and agreement.

In summary, the managers in both organization care about their personal relationship with managers at the counterpart. Self controls and the open-handed agreements between the managers at this level seem to have affected the social norms of agreement for the whole PPP towards a norm of trying to reach agreements.

4.5.2 Self controls in HealthcorpSub's relationship with the Largehospital orthopedic clinic

The majority of the employees at HealthcorpSub are working in the same clinics as they did before they became privatized. They still have the same values and motivation factors as they have had their whole carrier. Common for practically all interviewed healthcare personnel in this study is the personal vision to treat every single patient in the best possible way. This is prioritized over other factors such as cost, contracts or the best for the own organization. A very typical main motivation factor sounds like this answer from a Largehospital orthopedic clinic

employee: *"I want to give my patients the best possible treatment in everything from personal encounter, correct medical assessment or the best possible surgery."*

The view that the best for the patient is always the strongest argument, have proven to be a important common ground to settle around when there is a disagreement in HealthcorpSub's inter-organizational relationships at all levels. However, this might be particularly true in the relationship with the orthopedic clinic. There is a historical rivalry and social controls saying that the own organization should be prioritized, but when argumentation arises about where a patient should be sent or similar the patient oriented self control often solve the problem.

Moreover, sometimes doctors, both on HealthcorpSub's and Largehospital's orthopedic clinic, take care of patients themselves even though the patient should have been sent to the other hospital according to the contract. This implies costs for the own clinic and is contradictory to the social control to prioritize the own hospital. However, it seems as if the self control to take care of every unique patient in the best way is so strong that if a doctor think that he can treat a patient equally good as anyone else, it is hard for him to send the patient away. Such a self control is true, even in the light of limited resources, as expressed by the manager of Largehospital orthopedic clinic: "*When you have met the patient and established contact and think that you might cure him as good as anyone else, it might happen that the patient slips through the system." … "Then that resource are not left for someone else that might need it more."*

In summary, best for the patient is of highest priority. This helps the parties to reach pragmatic solutions. The self controls of prioritizing the patient is in line with the social control to act in the best interest of the patient, and counteracts the social impulses stemming from the historical rivalry.

4.5.3 Self controls in HealthcorpSub's relationship with the Smallhospital medicine clinic

The patient focus, explained above, is equally strong for the persons involved in the relationship between HealthcorpSub and the medicine clinic as they are in HealthcorpSub's relationship with the Largehospital orthopedic clinic. However, in contrast to the latter the collaboration do not rely so much only on this.

Employees at HealthcorpSub generally identify themselves firstly as employees at their respective clinic and their profession and secondly with Smallhospital. The feeling of fellowship with the Healthcorp Group is generally low. This is expressed as follows by a nurse at HealthcorpSub:

"I sympathize more with Smallhospital than with the Healthcorp Group… Locally [in terms of HealthcorpSub] I can understand it but with the Healthcorp Group I cannot see that I am part of it." … "I am proud over my work and that the work that we do because I can see that it is safe for the patients and that the patients appreciate it and are happy when they leave our clinic, so I am very proud over our clinic." … "But cannot say that I am proud to work within Healthcorp Group, it feel foreign to me in some way."

The self controls in the relationship between HealthcorpSub and are well in line with the social controls affecting the relationship. Personnel at HealthcorpSub and the medicine clinic have strong personal connections to Smallhospital. Many of the employees have grown up in the small

city close to the hospital and worked at Smallhospital for the most of their career. There is no doubt that these employees identify with the hospital on a personal level and want it to prosper. Thus, the self controls are highly aligned with the social controls and further encourage collaboration for the best of Smallhospital.

The view that as long as a clinic is located at Smallhospital it is not so important which organization it actually belongs to, is common both at HealthcorpSub and the medicine clinic. As expressed by a doctor at the medicine clinic: *"I mean, we are still one hospital, even if we are operated in different forms [public versus private]. We will have a doctor party at the hospital in April."* Many do not feel that there was a big difference when the operations of HealthcorpSub first became private. Instead they refer to the large reorganizations 1992 and 2004 as more important changes to the orthopedic clinic at Smallhospital.

Moreover, people at Smallhospital know each other well, as exemplified by a nurse at the medicine clinic: "*Everybody says hi to everybody and you know roughly that she works at that at that clinic and she works there."* … *"You know roughly, even if I do not know what everybody's name is, I can place the people somewhat correctly*." There is a difference in how you act if you know someone and look that person in the eyes and if you just have to make a phone call or send an e-mail and tell someone that you will not collaborate in the way he or she wants. This is expressed like this by a doctor at the medicine clinic when he is explaining why he might be more open-handed in the relationship with HealthcorpSub than with clinics at Largehospital: *"... It also depends on who it is. It is also a difference when you do not see each other in the eyes, then you get much tougher. It is like writing an e-mail…"*

In summary, employees of both organizations identify strongly with the Smallhospital and want to do what is best for the hospital as a whole. This reduces organizational boundaries and stimulates collaboration.

4.5.4 Summarizing the use of self controls

The use of self controls observed in the three inter-organizational relationships is summarized in the table below.

County Mgmt. - HealthcorpSub	**Largehospital orthopedic clinic – HealthcorpSub**	**Smallhospital medicine clinic – HealthcorpSub**
• Care about their mutual personal relationship • Open-handed agreement → Seems to have set social norms of agreement	• Best for patient is prioritized → Generates pragmatic solutions → In line with social control impulses of what is best for patient → Counteract the social controls impulses from rivalry	• Best for patient is prioritized → Collaboration • Employees need to see each other in the eyes • Both groups identify strongly as a Smallhospital employees → Reduces organizational boundaries

Table 3. Overview of the main self controls relevant for the three inter-organizational relationships studied.

5. Discussion

In the previous case analysis section, the use of administrative-, social- and self controls in the ongoing operations of the three inter-organizational relationships were accounted for. In this section of the thesis, the use of inter-organizational controls will be related to the control problems of appropriation concerns and coordination requirement. A theoretical dimension is thereby added as appropriation concerns and coordination requirements may explain the use of inter-organizational administrative-, social- and self controls in the PPP.

The section is structured as follows. Firstly, we discuss how appropriation concerns and coordination requirements can explain the three types of controls in each of the three inter-organizational relationships resulting from the PPP. In a second step, we compare and contrast how the control problems are handled in two of the relationships.

5.1 Main appropriation concerns and coordination requirements in the PPP

5.1.1 Appropriation concerns

As stated in section two, appropriation concerns correspond to impulses to safeguard ones investment from being appropriated by the other potentially opportunistic actor in the inter-organizational relationship (Dekker, 2004, 2008). In the PPP studied, such concerns would imply that the public counterpart(s) and the private counterpart respectively are worried about the other party exploiting the partnership in a disadvantageous way. HealthcorpSub's contract with Niceville County is financially important for both parties and written over several years.

In inter-organizational relationships, contracts suffer from bounded rationality issues that limit the possibility to write complete contracts covering every potential future contingency, limiting the possibility to mitigate appropriation concerns (Dekker, 2004, Gulati and Singh, 1998). The contracted specialized healthcare services are complex. In addition, technology and best practices change over time, further increasing unpredictability. Thus, it was difficult to write a complete contract. The County Management and HealthcorpSub chose to write a contract that was quite general in its formulations, maintaining flexibility to handle future unexpected contingencies. However, the incomplete contract implies that some remaining appropriation concerns needs to be handled by additional controls.

5.1.2 Coordination requirements

The second control problem involves coordination requirements, as HealthcorpSub and the three Niceville County public units jointly need to deliver healthcare, divide and coordinate tasks across organizational borders. According to Gulati and Singh (1998), coordination and joint decision-making requirements increase with higher interdependence and higher uncertainty. As mentioned above, uncertainty is rather high, which characterizes all three inter-organizational relationships. In contrast, the level of interdependence differs between the three relationships, resulting in different degrees of coordination requirements.

5.2 Control problems in the three inter-organizational relationships

Since appropriation remains following the openly formulated contract, and coordination requirements differ between the inter-organizational relationships studied, it is relevant to take a closer look at them separately. In this sub-section, we therefore discuss how the control problems, appropriation concerns and coordination requirements, can explain the use inter-organizational controls in the three relationships in the PPP. Thereby we also discuss how the control problems are handled by the three types of controls.

5.2.1. Control problems in HealthcorpSub's relationship with the County Management

As stated above, appropriation concerns remain following the openly written contract. County Management and HealthcorpSub are the main counterparts in the PPP contract. Hence, it is in this relationship that the remaining appropriation concerns with regards the contract and overall functioning of the PPP are handled.

In contrast, the coordination requirements are not very significant in this specific relationship. Instead, the counterparts are responsible for setting the structure to handle coordination requirements in other two relationships, where actual healthcare services are provided. However, this situation do imply joint decision-making requirements, as HealthcorpSub and the County Management need to agree on the common structure and resolve any contract related issues.

Administrative controls

Since the remaining appropriation concerns with regards the contract and overall functioning of the PPP are handled in this relationship, the general administrative control structure for HealthcorpSub's operations within Niceville County is set between HealthcorpSub and the County Management.

Handling of appropriation concerns

Firstly, one way to handle the appropriation concerns from the County Managements perspective is to use goal related payments. However, as the complexity of tasks implies measuring problems, using an extensive incentive system with goal related payments could result in opportunistic behavior from the counterpart. HealthcorpSub may exploit such a system and optimize revenues at the expense of non-measurable quality factors. Similarly, from HealthcorpSub's perspective, too much goal related payments would imply appropriation concerns, as their results are largely dependent on the public units due to the centralized referral handling and interdependence in operations. As a result only two goal related payments are used in the PPP: customer satisfaction and availability. Regarding the first goal related payment, customer satisfaction, this KPI might be hard to measure in a totally fair way. However, the measure is so general that the County Management do not need to worry for HealthcorpSub acting opportunistically and optimizing this factor on the expense of other. From HealthcorpSub's perspective, this incentive makes sense as it is well aligned with their own interest to maximize customer satisfaction. Regarding the second measure, availability, having a maximum number of days when waiting for surgery is a legal right for Swedish citizens. Thus, availability was naturally included as a demand on

HealthcorpSub for receiving payment for a patient. Also, availability is easy to measure. However, still some adjustment had to be done in the contract with coordination requirement related issues, such as how late a patient could be sent to HealthcorpSub for this rule to apply.

Secondly, HealthcorpSub are required to report a number of additional KPIs, even though the parties did not connect KPI performance to payments here. This implies a monitoring possibility for the County Management and should decrease appropriation concerns. However, as described in the case analysis it is in the interest of HealthcorpSub to disclose KPIs and other quality-related information. This is a way to market the business and decrease appropriation concerns from other interest groups, including patients and politicians as well as other counties and insurance companies that purchase surgeries from HealthcorpSub.

Thirdly, appropriation concerns exist related to the relationship between the HealthcorpSub and the Largehospital orthopedic clinic and the handling of referrals and patient flows. Having the overall responsibility, it is in the interest of the County Management that referrals and patients flows are well functioning. The parties have therefore agreed to allocate referral handling to a centralized function reporting to the County Management. Hence, the County Management retains administrative control over this function. However, HealthcorpSub's management does not experience this as a problem. Both parties refer to the centralization of this function as an efficient way to handle coordination requirements.

Handling of coordination requirements

The openly formulated contract was needed to handle the unpredictability, but it increases the need for additional controls and requires continuous adjustments. It is crucial for both parties to handle the need for interpretation of contract terms and continuous improvement of the contract, which implies coordination requirements. Therefore, a structure of regular meetings has been set up, as described more in detail at page 31. Some of the meetings are mandatory by contract, but it is also of mutual interest to attend. Regular meetings between (i) HealthcorpSub and the Largehospital orthopedic clinic and (ii) HealthcorpSub and the Smallhospital medicine clinic, aim to handle coordination requirements. On the other hand, appropriation concerns, such as contract issues and questions with significant financial impact are passed on and handled in the controller meetings. This separation of coordination requirements and appropriation concerns can be seen as a way to make sure that coordination requirements are handled in the most efficient way, without the Head of Clinics worrying for the financial implications of the solution. Instead, any contract adjustments are done by the Contract responsible at the County Management and the CEO of HealthcorpSub. The high number of meetings between parties at all levels can also be seen as a strategy to create personal relationships and draw on the collaboration-encouraging effect of face to face meetings, discussed in the case analysis.

Social Controls

The fact that the County Management and the management of HealthcorpSub knew each other well already before the privatization have been described above. Good historical relationships decrease the appropriation concerns for both parties. Much of the social controls from the time as a public unit still remain in place at HealthcorpSub. Sharing the same social controls have decreased the perceived organizational boundaries. Particularly from the County Management's

perspective this seems to have mitigated appropriations concerns, as an important part of social controls includes an aim to provide the best possible care as well as caring for tax payers money. Hence, this increases the County Management's goodwill trust in HealthcorpSub as they can expect them to act not only in favor of the own organization, but also take the County's costs into account.

Management from both the public and private organizations expresses capability trust in the other organization, as they know it have worked well historically. However, the County Management seems to have some appropriation concerns with regards to the ownership of HealthcorpSub. The County Management might to some degree be affected by the public debate about private healthcare. Also, the shared social controls described as playing such an important role in the relationship above do not seem to be as well aligned in the relationship between the County Management and the Healthcorp headquarters. This concern affect the County Management's relationship with HealthcorpSub and might be what the HealthcorpSub manager expressed when he concluded that the County Management scrutinizes them harder than public clinics. This appropriation concern can probably be explained by lack of the same social- and self controls that has been described as important for decreasing appropriation concerns above. Hence, social- and self controls makes a difference in handling appropriation concerns.

Self controls

The good personal relationships between the managers of HealthcorpSub and the County Management decreased the uncertainty in the beginning of the relationship. Both parts knew that the counterpart's management shared their own, long term, open-handed approach to managing a relationship. This of course implied less concern for opportunistic behavior. Their good historical relationship was probably the reason why they dared to write the contract this way, despite of the significant appropriation concerns. Also, this approach decreases coordination requirements as the need for discussions and hard negotiations is reduced.
All in all, self controls are similar to and well aligned with social controls in the relationship between HealthcorpSub and the County Management.

Summary

In summary, the relationship between HealthcorpSub and the County Management focuses on managing appropriation concerns and coordination requirements for the functioning of the overall PPP. Regarding administrative controls, appropriation concerns are handled by monitoring, some goal related payments and a centralized referral system. The openly written contract requires a structure for coordination and joint decision-making, which is set up by a number of meetings. Moreover, the extent of administrative controls has been affected by the strong social- and self controls that encourage collaboration and being open-handed. Personal relationships, well aligned social- and self controls and a history of successful collaboration play an important role in mitigating appropriation concerns and decreasing coordination requirements. However, the County Management's appropriations concerns related to the private ownership are enhanced by the lack of alignment of the same social- and self controls in the relationship with Healthcorp headquarters.

5.2.2. Control problems in HealthcorpSub's relationship with the Largehospital orthopedic clinic

HealthcorpSub and the Largehospital orthopedic clinic collaborate to provide complete orthopedic services to Niceville County. However, as the two organizations are in the same business (orthopedic specialty), they could also be seen as competitors. Therefore, appropriation concerns, specific to this relationship, includes the other part taking over business from the own organization. However, in a setting where all patients need to be treated at one of the clinics, appropriation concerns also exist related to a counterpart avoiding the most complicated/high-risk patients that stand for a large part of total costs.

Coordination requirements in this setting include division of tasks and sharing informing about patients sent between the clinics. However, given that the clinics do not treat the same patients in a sequential manner, the coordination and joint decision-making requirements are moderate.

Administrative controls

As explained above, many of the administrative controls in HealthcorpSub's relationship with the Largehospital orthopedic clinic are set by the overall contract. However, as the contract is written in general terms many of the operational questions with regards to HealthcorpSub's collaboration with the Largehospital orthopedic clinic are open for interpretation and require coordination. These coordination requirements, including operational collaboration issues and practical interpretations of the contract terms, are generally handled through the Niceville County collaboration meetings. The meetings are set up for the orthopedic clinics in Niceville County to discuss operational collaboration and task division, as well as any countywide medical issues, such as treatment standards. Finally, some coordination requirements are also handled sporadically between managers or doctors in duty over phone or e-mail.

Regarding appropriation concerns, the decision of which patient that is to be sent to which clinic have a significant financial effect. As described above, the majority of the referrals are sorted by a centralized function established by the County Management. However, the assortment criteria are discussed at the collaboration meetings. Hence, issues regarding referral assortment can be handled. Moreover, doctors at both clinics thereby have the possibility to affect where patients end up.

Social controls

The social- and self controls in HealthcorpSub's inter-organizational relationship with the Largehospital orthopedic clinic are influenced by a historical rivalry between Smallhospital and Largehospital. This rivalry stem from competing for the same business, and possibly opportunistic behavior, before HealthcorpSub was established. However, some distrust for HealthcorpSub as organization and the fact that it is a private company are also found among managers and employees at Largehospital orthopedic clinic. The worry for the other organization to act opportunistically and exploit the other part is the reason for the appropriation concerns in both cases. The decision of which patient that is sent to which clinic has a financial effect and thus appropriation concerns exists.

However, the appropriation concerns are to some degree contradicting. The concern based on historical rivalry is related to a worry that the other hospital should take on too many tasks and patients. However, the appropriation concern resulting from HealthcorpSub being a private company are mainly related to a worry about them avoiding costs by taking on too few patients. One explanation for this could be that the concerns are from different levels of the organizations. While managers worry about costs, the doctors worry about the clear-cut work division and want to sustain as wide competence as possible as well as freedom to cure every patient in front of them. Thus, professional social controls differ from managers' focus on costs.

However, despite the appropriation concerns the collaboration between the organizations works relatively well. To a large degree this is due to the social control to act in the best interest of the patient, present at both parties.

Self controls

Despite the lack of personal relationships or personal sympathy for the other organization, self controls decrease appropriation concerns and coordination requirements. This is due to that the absolute strongest self control at both clinics is caring for each patient's best. Thus, it does not matter if social control implies that a patient should be sent to the other "competing" clinic. When the doctors see a patient in the eyes, he wants to do what is best for the patient. This decrease coordination requirements, but also appropriation concerns as it ensures that patients are not sent to the other clinic for financial reasons.

Summary

The County Management and management of HealthcorpSub set the main structure of administrative controls in the relationship between HealthcorpSub and the Largehospital orthopedic clinic. However, appropriation concerns with regards to the ongoing business are to a large degree handled by management of the orthopedic clinics, generally at Niceville collaboration meetings. The main function of these meetings is to handle coordination requirements including operational collaboration issues and practical interpretations of the contract terms. Historical rivalry between the clinics and some distrust towards HealthcorpSub's private ownership increase appropriation concerns, although these are counteracted by the common social- and self control centered on what is best for the patient. Still, the historical rivalry and low degree of trust decrease spontaneous communication that might be useful for coordination.

5.2.3. Control problems in HealthcorpSub's relationship with the Smallhospital medicine clinic

HealthcorpSub's inter-organizational relationship with the Smallhospital medicine clinic is to a lesser extent characterized by appropriation concerns. The contract handles the main appropriation concerns. Moreover, the general terms in which the contract is written do not result in any significant appropriation concerns, as there are few situations of profit or cost splits. Instead, there is a larger need to handle coordination requirements. This is due to the fact that the clinics sequentially or simultaneously treat the same patients and need to cooperate extensively in daily operations. Hence, relating to Gulati and Singh (1998), the coordination and joint decision-making requirements are more extensive due to the higher interdependence.

Administrative controls

In this inter-organizational relationship, the administrative controls are mainly set up to handle coordination requirements. The collaboration between the clinics is to a large degree handled by detailed processes and memos. The inter-clinic improvement group aims to find new solutions and improve these processes. If minor appropriation concerns arise they can also be discussed in this forum.

Moreover, as both Head of Clinics, doctors and nurses often meet face to face in this relationship many collaboration requirements can be handled in sporadic contact directly between the managers. However, to secure knowledge sharing and full implementation, joint operational processes are written into memos.

Social controls

HealthcorpSub's inter-organizational relationship with the Smallhospital medicine clinic differs from the other two studied relationships in that appropriation concerns between the two clinics are low. This is due to tight collaboration and the fact that there are few situations where they have to split profit or costs. Instead the parties' interests are rather well aligned. Also, the employees from both organizations tend to prioritize the best for Smallhospital. Hence, goodwill trust is high. Furthermore, capability trust is highly present as the employees can observe the other organization's capabilities in their everyday work.

Instead the coordination requirements are high. However, the coordination requirements are handled to a large degree by well-aligned social controls. The mentioned "Smallhospital spirit" and mutual dependence on each other reduce the effect of organizational boundaries as it creates, not only common goals, but also a feeling of being in the same organization.

Self controls

The self controls and social controls are quite well aligned in the relationship between HealthcorpSub and the Smallhospital medicine clinic. Many employees from both organizations identify strongly with Smallhospital on a personal level and really care for the best for Smallhospital. Many employees have personal relationships with employees in the other organization that they care for. Also, the close collaboration implies that much of the interaction is face to face. Hence, self controls mitigate appropriation concerns and decrease coordination requirements.

Summary

Administrative controls in HealthcorpSub's inter-organizational relationship with the Smallhospital medicine clinic are mainly focused on handling the significant coordination requirements. Regular meetings play an important role to improve routines and standards. However, as both managers and personnel meet face to face at work many matters are discussed sporadically and then written into memos. Appropriation concerns are low and the social- and self controls characterized by a high level of trust. Well aligned social- and self controls encourage cooperation for the best of Smallhospital enhance the collaboration and decrease coordination requirements significantly. For operational reasons appropriation concerns are not

very high from the beginning. Moreover, the fact that the employees know each other and often meet face to face further decrease such concerns.

5.2.4 Comparison between HealthcorpSub's relationship with the Largehospital orthopedic clinic and the Smallhospital medicine clinic

Two of the inter-organizational relationships in the PPP operate on the same hierarchical level, i.e. where the actual healthcare services are provided to patients. These relationships are (i) HealthcorpSub's relationship with the Largehospital orthopedic clinic and (ii) HealthcorpSub's relationship with the Smallhospital medicine clinic. Still, the two relationships differ in terms of controls and control problems. Therefore, these relationships are interesting to compare and contrast, and such an analysis is conducted below.

Appropriation concerns are present to a higher degree in the relationship with the Largehospital orthopedic clinic while coordination requirements are the main issue to handle in HealthcorpSub's relationship with the Smallhospital medicine clinic. Two main reasons for this difference have been found: (i) differences in social controls and (ii) operational differences, in terms of to which degree there is a profit/cost split in the relationship and the level of interdependence and complexity of the coordination.

Firstly, a high level of trust and strong social control that mitigate appropriation concerns, characterizes HealthcorpSub's collaboration with the Smallhospital medicine clinic. In the relationship with the Largehospital orthopedic clinic the social controls of rivalry between the clinics seems to increase appropriation concerns.

Secondly, the fact that there is a higher degree of profit and cost split in HealthcorpSub's relationship with the Largehospital orthopedic clinic than in the relationship with the Smallhospital medicine clinic, implies that worries for the counterpart to act opportunistically is higher from the beginning. A focus on collaboration in HealthcorpSub's relationship with the medicine clinic is also logical since the coordination is complex and intense in this relationship.

The causality in this situation is not clear-cut. The social controls clearly affect the appropriation concerns and coordination requirements. However, social controls might not have looked the way they do in these relationships if it was not for the appropriation concerns and coordination requirements in the first place. Thus, these factors seem to affect and reinforce each other.

5.3 Summary of discussion

Finally, we can conclude that the appropriation concerns and coordination requirements observed in the three inter-organizational relationships within the studied PPP differ from each other. The control problems are all handled by administrative- social- and self controls, but the combination and significance of the different controls differ. However, it is difficult to establish whether social- and self controls substitute or complement administrative controls in managing appropriation concerns and coordination requirements. Given that the observed controls differ between the relationships, it is relevant to consider more than just one inter-organizational relationship in complex PPPs.

6. Conclusion

6.1 Summary and main conclusions

In this thesis, we aimed to investigate the ongoing use of controls in a PPP within the healthcare sector in Sweden, involving one private counterpart and three inter-related units in the public counterpart. The aim was specified into two research questions where the first question aimed to investigate how administrative-, social- and self controls are used in the ongoing operations of the three inter-organizational relationships. In a second step, we examined how appropriation concerns and coordination requirements may explain the use of inter-organizational controls.

To answer our research questions we used Hopwood's (1974) framework of controls, extended into the inter-organizational setting, for analyzing the ongoing controls used in the PPP. Secondly, Dekker's (2004) control problems of appropriation concerns and coordination requirements were applied to the controls found as a means to explain the use of inter-organizational controls.

To begin with, we found that administrative-, social- and self controls played a role in all three inter-organizational relationships, although the balance between the controls and their respective importance varied between the relationships. Similarly, both appropriation concerns and coordination requirement contribute to explaining the inter-organizational controls in all three relationships.

Moreover, social- and self controls proved to mitigate appropriation concerns and coordination requirements. Social- and self controls are important control forces in the PPP overall, they are likely to have enabled writing the procurement contract in such an open and less detailed manner. The importance of social- and self controls are in line with for example the findings of Carlsson-Wall et al. (2011). Thereby, our case study reaffirms the need for a broad conceptualization of control, including these two controls (Hopwood, 1974; Caglio and Ditillo, 2008; Van der Meer-Kooistra and Scapens, 2008).

The concluded importance of self- and social controls also supports the view of Broadbent et al. (2003, cited in Andon, 2012) who promote the role of trust and a relational contracting approach rather than overly reliance on contractual form. Our findings show that social- and self controls in the public-private relationship play an important role in ensuring a cooperative relationship and decreasing appropriation concerns. The study also demonstrate the importance of historical relationships in creating social controls, mitigating appropriation concerns and reducing coordination requirements. This in line with the multiple PPP case study by English and Baxter (2010), in which they show that uncertainty over time was gradually handled more by goodwill trust and relational contracting while new contracts were written in a less specified manner. However, in line with previous research, it is still difficult to establish whether social controls substitute or complement administrative controls in managing appropriation concerns and coordination requirements (Dekker, 2004).

In summary, within the same PPP, we have observed different combinations of inter-organizational controls (administrative-, social- and self controls) in three different inter-organizational relationships. Moreover, the importance of the two control problems (appropriation concerns and coordination requirements) in explaining the use of inter-organizational controls varies between the relationships.

6.2 Contributions to research

Contributions to existing research include taking a broader approach to control in PPPs by including the social- and self-controls in addition to the administrative controls. Within the field of PPPs, this has previously has been done to a limited extent. Previous research has also tended to be done at a distance from the actual operations and people engaged. As a result, we contribute by examining day-to-day inter-organizational control. Furthermore, we contribute by studying three inter-organizational relationships between one private actor and three public units. As a result, we go beyond the traditionally dyadic approach to PPP research.

Secondly, we contribute by studying the contradictions between contractual governance and the need for cooperation, that simultaneously characterize PPPs. Similarly to previous research, we conclude previous relations and trust-building to be important complements to administrative controls. It is also recognized that the importance of social controls appears to be connected to the specific case study setting.

Thirdly, Andon (2012) brought up internationalizing knowledge on PPPs as an additional theme of required research. We contribute by adding a Swedish case study to a body of literature that to a great extent center around the UK and other Anglo-Saxon countries.

6.3 Limitations and suggestions for further research

When discussing the conclusions of the study, it is relevant to consider the limitations of the study. The purpose of a qualitative single case study is primarily exploration and knowledge building, meaning that additional and more comprehensive studies are required in order for results to become more generalizable. In addition, as touched upon in the method section, the authors' interpretations may have affected the findings. However, in order to prevent such a bias and strengthen the reliability of the study, a structured method was applied for processing and analyzing the data. Finally, it should be recognized that specialized healthcare is a specific empirical setting, potentially restricting the applicability of results across other sectors.

Against this background, there is potential to conduct further studies on controls in continuous operations of PPPs. Additional case studies on several inter-organizational relationships resulting from one PPP within the healthcare sector, as well as across other sectors, constitute interesting further research topics. Moreover, it would be interesting to examine how inter-organizational controls in a PPP develop over time in a longitudinal study. The importance of appropriation concerns and coordination requirements as well as the use of different inter-organizational controls are likely to fluctuate over time and potentially between phases in the PPP contract.

Finally, there is potential for researchers to make cross-country comparisons on how PPPs are operationalized, in order to compare and contrast control practices and their rationales across cultures, legal jurisdictions and political environments.

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8. Appendix

Appendix one: conducted interviews

Interview	Date	Title	Organization
1	Feb 12th	County Council Chief Financial Executive	County Management
2	Feb 12th	Contract Responsible	County Management
3	Feb 13th	Doctor and Head of Clinic	Largehospital orthopedic clinic
4	Feb 13th	Smallhospital Chief Executive	County Management
5	Feb 13th	Doctor	Largehospital orthopedic clinic
6	Feb 14th	CEO HealthcorpSub	HealthcorpSub
7	Feb 14th	Doctor and Head of Clinic	HealthcorpSub
8	Feb 27th	Healthcare Director	County Management
9	Feb 27th	Healthcare Strategist	County Management
10	Feb 27th	Financial Director	Smallhospital Administration (public)
11	Feb 27th	Doctor	HealthcorpSub
12	Feb 28th	Nurse and Head of Ward	HealthcorpSub
13	Feb 28th	Doctor and Head of Clinic	Smallhospital medicine clinic
14	March 19th	Nurse and Head of Ward	Smallhospital medicine clinic
15	March 19th	Doctor	Smallhospital medicine clinic
16	March 19th	Nurse	HealthcorpSub
17	March 20th	Referral Responsible	County Management
18	March 20th	Business Controller	Smallhospital Administration (public)
19	March 20th	Assistant Nurse	HealthcorpSub
20	March 20th	Nurse and Head of Clinic	Smallhospital medicine clinic
21	March 20th	Assistant Accountant	HealthcorpSub
22	March 20th	Accountant	HealthcorpSub