Stockholm School of Economics
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Value-Based Inspired Reimbursement Model for Primary Care

- A qualitative case study of a pilot in Stockholm

ABSTRACT: Primary care in Sweden is experiencing a continuous increase in costs, difficulties in delivering intended care, and uneven quality for patients. Analysts are concerned with how to improve the quality of the care provided while controlling the healthcare expenditures. The importance of the manner in which primary care is reimbursed is well recognised, but the optimum design of a reimbursement model is under debate. Structurally different reimbursement models can create incentives for innovation initiatives aiming to improve the processes, efficiency and quality in the care provided. Despite this, there is scarce research on how reimbursement models can incentivise innovation. Stockholm County initiated a pilot project in January 2016 with the intention to test a new reimbursement model at four primary care centres in Stockholm. The aim of the reimbursement model is to allow for greater freedom to innovate while increasing quality and maintaining accessibility. The purpose of this study is to investigate how this reimbursement model afford primary care practitioners to pursue different innovations. Twenty-one interviews, with 5 initiators of the project and 16 members of the participating primary care centres have been conducted in a multiple case study. The results indicate that the reimbursement model afford primary care practitioners to pursuance an overarching strategic goal to improve care for patients, especially elderly chronically ill, and multi-sick patients. Incentives concerning longer appointments, accessibility, and redesigned processes providing more responsibility for nurses are the areas which receive most attention. The study thereby advances the knowledge of reimbursement models and innovation, and what design features that may shape this relationship.

KEYWORDS: *Reimbursement Models, Value-Based Healthcare, Innovation, Balanced Scorecard, Affordance*

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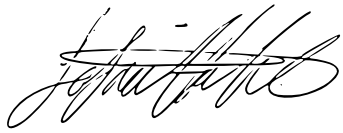

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Acknowledgements,

ANNA ESSÉN

For your advice, support and infinite encouragement through the world of music

Don't stop believing

PAMELA MAZZOCATO and **CARL SAVAGE**

For inviting us to this exiting project

We will rock you

FAMILY and **FRIENDS**

For always being there

School's out

OURSELVES

Yes.

We are the champions

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Glossary

BSC	Balanced scorecard
FFS	Fee for service, reimbursement based on completed activities
HSF	Hälso sjukvårdsförvaltningen, responsible for the Stockholm County's residents have access to a good and safe healthcare, purchaser organisation within SCC and initiators of this project.
KI	Karonlinska Institutet
MMC	Medical Management Centre, focuses on how, knowledge, competence and resources are best utilised to improve human health
NPM	New Public Management, management approach inspired by private sector to design and organize the public sector
PCC	Primary Care Centre, unit for open healthcare
P4P	Pay for performance, reimbursement based on achieved results
RM	Reimbursement model
SCC	Stockholm Läns Landsting, Stockholm County Council is primarily responsible for society's publicly funded healthcare.
VBHC	Value-based healthcare, management framework focusing on increased quality and minimal costs

1. Introduction

There are severe efficiency and development problems in the Swedish healthcare sector (Blanck, 2014; Stiernstedt, 2016). Costs have continued to rise and primary care is reported to have the highest cost increase of all healthcare services (Socialstyrelsen, 2012). Analysts claim that structural problems in making care more efficient have been neglected and resources are not used optimally. The primary care in Sweden experience difficulties in delivering the intended care and was recently described as less equipped than in other countries to handle demographical changes implying more multi- and chronically ill patients as the population is aging (Stiernstedt et al., 2016). The experienced challenges in delivering good care are receiving growing attention as the quality of care is increasingly uneven. However, the problems in healthcare are not due to lack of hard work, skills or commitment but rather the structure of healthcare delivery, how it is reimbursed, organised and practiced (Porter, 2006, 2009).

The great importance of how primary care centres (PCCs) are reimbursed is well recognised, but the exact design of the optimum reimbursement model (RM) is under debate (Ellis, 1986; Frolich et al., 2007; Christensen, 2009). The launch of new RMs are usually only a fraction of larger reforms and it is unclear what outcomes RMs trigger (Lindgren, 2014). The structure of the RM may not only affect the costs, but it may also create incentives for improving the processes, efficiency and quality in the care provided (Lindgren, 2014). Furthermore, scholars have argued that the design of the RM may be a prerequisite for how much the personnel will be able and willing to innovate the healthcare service (Frolich et al., 2007) since it can create both incentives and financial opportunities for innovation initiatives to create value and improve the care provided (Porter, 2008; Lindgren, 2014; Örtenblad, 2016). Despite this, there is scarce research on how RMs affect innovation (Frolich et al., 2007), and how the innovations should be measured (Wolfe, 1994; Adams et al., 2006).

1.1 Background

As a response to the perceived constrains in the existing RM, Stockholm County Council (SCC) and Hälsosjukvårdsförvaltningen (HSF) has initiated a project with the intention to *"provide greater freedom for caregivers to design their organisation around their listed patient's needs. The aim of the project is to increase the provided quality for patients while maintaining accessibility"*. The project is known as *"Kroninnovation"*, a pilot that aims to design, implement and evaluate a new RM within primary healthcare in Stockholm (Winberg, 2015). This thesis takes a foothold in that project.

Primary care in Sweden has been heavily influenced by reforms during the last years (Lindgren, 2014). Previously New Public Management (NPM) inspired approaches have been strong within healthcare in Sweden as well as internationally, aiming to improve efficiency and effectiveness through applying a business mindset in healthcare. However, research has identified several shortcomings, such as increased centralisation and misallocation of time and resources associated with attempts to implement NPM approaches (Diefenbach, 2009). Value-Based Healthcare (VBHC), as defined by Porter (2006; 2008; 2009; 2010; 2013) can be viewed as a response to the perceived problems with the NPM-inspired approaches. While VBHC is a general framework that is understood and implemented variably (Örtenblad, 2016), the framework as presented by Teisberg and Porter (2007) emphasises a need for governance agencies to shift their focus from the process to the total outcomes of care, and to allow care providers more flexibility in how they deliver care. VBHC systems should focus on delivering increased quality with minimal costs (Porter, 2009). The intention of the presented project was to develop a more value-based RM in Stockholm County, with increased focus on elderly, chronically ill and multi-sick patients, allowing for innovation height at the PCCs[1].

[1] Kroninnovation was developed as a pilot by the initiators; HSF, Idérådet, IVBAR and KI in 2013 and 2014, and rolled out in its entirety at four PCCs in western Stockholm in January 2016. The outcomes and effects of the project will be evaluated at several occasions during 2016. This is the first time HSF evaluate the implementation of a new RM, and this thesis is the first evaluation of the project.

In the Figure 1.1 below a description of the main components of the new RM is presented, which are also the components in focus for this thesis. The RM is complex and a full list of all the components can be seen in Kroninnovation (2015).

Figure 1.1 Main Changes of new RM

Change in RM	Details of change
Increased reimbursement for listed patients (capitation)	The fixed share of the reimbursement for listed patients is increased from approx. 40% to 70%. The variable share of the total reimbursement for appointments consequently decrease from approx. 60% to 30%.
Weighted reimbursement based on socioeconomics and need of care	The level of fixed reimbursement is adjusted to each PCC based on socioeconomic factors and need of care of their listed patients. ACG (Adjusted Clinical Groups) and CNI (Care Need Index) are used as measures to adjust the level of reimbursement to each PCC.
Appointments are reimbursed equally for doctors and nurse	Doctors have previously received higher reimbursement for appointments than nurses The new model has equal reimbursement for doctors and nurses.
Reimbursement for video appointments	Video appointments will be introduced and reimbursed as if the patient would have physically met a healthcare professional.
Reduced reimbursement for specific activities (KVÅ-codes)	Specific activities (KVÅ-codes) are reimbursed in addition to the reimbursement of appointments. These specifically reimbursed actions will be fewer with the new RM.
Increased reimbursement for home care	The reimbursement is increased for visiting the patient at their home relative to previous RM

SCC and HSF want the new RM to allow an increased freedom for the PCCs to develop the delivery of healthcare services in the best possible way by promoting innovation initiatives that aim to deliver higher quality for patients (Kroninnovation, 2015). Innovation is a highly debated topic, yet there is little research on how RMs can incentivise innovation and what types of innovations different structures of RM can afford (Lindgren, 2014). By evaluating how the new RM has been implemented and what innovation initiatives that have been carried out, SCC and HSF hopes to understand if a value-based inspired RM is an appreciated RM for the value and quality in primary healthcare and something that should be implemented at all PCCs in Stockholm County.

1.2 Purpose of Study and Research Question

As mentioned above, the Swedish healthcare is experiencing efficiency and development problems, leading to difficulties in primary care to deliver the intended and needed care. How to handle this problem is an urgent and important question (Ellis, 1986; Christensen, 2009). Research has been made stating that the RM is important for determining to what degree the PCC can develop and innovate their organisations and the care provided (Lindgren, 2014). Nonetheless, we have identified few studies on how the structure of the RM affect what type of innovations the PCCs will initiate.

The purpose of this study is thereby to describe how a value-based inspired RM that aims to increase quality and efficiency influences innovation initiatives in primary healthcare through answering the research question:

"How does a new reimbursement model with the political intention of improving the quality and efficiency of healthcare afford primary care practitioners to pursue different innovations?"

Through answering this research question we will be able to identify how the RM afford the PCCs to translate it into types of innovation initiatives, hopefully aiming at improving the quality and efficiency of care provided. This allows us to contribute to the research gap of what types of innovations follow from the initiatives taken based on a new RM, indicating whether this or a similar value-based inspired RM should be implemented at all PCCs in Stockholm County. Furthermore, we use a Balanced Scorecard (BSC) to assess the innovation initiatives identified, hence this thesis also contributes to the research concerning BSC, investigating if it is a favourable approach to assess innovation initiatives within healthcare.

1.3 Delimitation

The timing and the time constraints for writing this thesis have limited the study to only focus on identifying the innovation initiatives that follow from the new RM and not quantitatively measure the effects of the innovations in terms of quality and efficiency. The pilot project went live on January 1st 2016 and most of the PCCs are expected to have a transition time where they successively initiate and implement innovation projects. A quantitative analysis will be made later this year by MMC to follow up the effects from the RM. Another delimitation of the study is the choice of analytical framework, since there are many aspects influencing the innovation projects which are not part of this analytical framework, such as organisational systems and management (Caldwell et al. 2008). Delimitations have been made in the development of the analytical framework with the purpose to develop a comprehensive framework focusing on the purpose of the study and research question.

1.4 Thesis Outline

This thesis is structured in eight chapters in order to allow the reader to easily comprehend and follow the contributions made. The first chapter is an **Introduction**, presenting an overarching description of identified problem and our purpose. Hereafter follows a **Literature review & Analytical framework**, introducing the theoretical foundation and framework developed to answer the research question. The **Methodology** chapter, explains and investigates the method used to conduct the data collection and analysis. In the **Empirical Results** we present our findings, structured according to our analytical framework. The **Analysis** chapter builds on the empirical results and connects them to the analytical framework. Thereafter follows a **Discussion** on our main findings together with a conclusion. Lastly **References** and **Appendixes** follow.

2. Literature Review & Analytical Framework

In this chapter a review of the literature used in this thesis is presented, focused on Value-Based Healthcare, Reimbursement Models in Healthcare and Reimbursement and Innovation. This is followed by the Identified Theoretical Gap and a presentation of our Analytical Framework developed for this study.

2.1. Value-Based Healthcare

Value-based healthcare (VBHC) is a management idea that refers to the aim of stimulating efficiency developments within healthcare while still being more cost conscious. VBHC was introduced in 2006 by Teisberg and Porter in USA and has since been partly adopted in several countries (Porter, 2009; Lindgren, 2014; Örtenblad, 2016). The main foundation of VBHC is that healthcare facilities should and must compete on patient value in order to deliver the best healthcare service possible to the lowest cost possible (Porter, 2007; 2009; 2013). The core concept of VBHC is:

$$\text{Value} = \frac{\text{Outcome}}{\text{Cost}}$$

Value is defined as "the health outcomes achieved that matter to patients relative to the cost of achieving those outcomes". To improve value one or more outcome factors must be improved without rising costs (Porter, 2007). Porter (2007; 2013) argues that an organisation must fulfil a "value agenda" that consists of six parts to become value-based:

1. Organise into integrated practice units
2. Measure outcomes and costs of every patient
3. Move to bundled payments for care cycles
4. Integrate care delivery across separate facilities
5. Expand excellent service across geography
6. Build and enabling information technology platforms

A key problem adressed in VBHC is the increased pressure and responsibility on doctors experienced in other management theories practiced. The aim of the system is to focus on mutually reinforcing elements such as diminishing the gaps between nurses and doctors and hence create a more functional balance and decreased hierarchy. Moreover, this is believed to lead to better healthcare services and value for patients (Porter, 2008; Latkovic, 2012). VBHC also highlights the importance of measuring performance and outcome, focusing on measuring medical conditions rather than speciality or intervention. By measuring the medical condition, the outcome cover the full cycle of care and the condition of the patient after care was provided. Examples of VBHC management activities are lean, balanced score cards, learning organisations, business process reengineering and team-based thinking (Örtenblad, 2016).

2.2 Reimbursement Models in Healthcare

Economic governance, financial statements and RMs are well-debated topics, especially within the healthcare sector (Ellis, 1986; Frolich et al. 2007; Christensen, 2009; Latkovic, 2012). Researchers agree that economic influences such as RMs have a great impact on how care is delivered, organised and practiced (Robinson, 1993; Luft, 2009, Latkovic, 2012). The importance of economic incentives in most western countries have increased during the last 30 years (Christensen, 2009). Researchers argue that mechanisms in current reimbursement systems not only fail to reward high-quality care but even reward failure or fail to reward healing (Latkovic, 2012). Decision-makers are increasingly applying market inspired RMs in healthcare to adapt to the demand for better cost control and efficiency, resulting in more sophisticated RMs (Christensen, 2009).

However, the evidence of how RMs impact the care delivery is fragmented and with mixed result since there is a disagreement on which is the superior structure of RMs (Robinson, 2001; Lindgren, 2014). Nevertheless, it is known that the structure of the RM can affect how the healthcare providers act and react to changes in their business environment (Ellis, 1986; Lindgren, 2014). Benefits and disadvantages

have been identified with all RMs. In Figure 2.1 below an illustration of different reimbursement structures and their effects is presented.

Figure 2.1 Description of Reimbursement Models

	Fixed		Variable		
	Fixed budget	**Capitation**	**Fee for service**	**Pay per performance**	**Value-based**
Description:	Reimbursement based on predetermined budget (fixed prospective reimbursement)	Reimbursement based on the population (number of people) the Caregiver is responsible for. Can be complemented with other socio-demographical factors such as ACG and CNI (fixed prospective reimbursement).	Reimbursement based on completed activities (retrospective, variable reimbursement).	Reimbursement based on achieved results. Are often used as a bonus in combination with other reimbursement structure	Reimbursement based on achieved outcomes in relative to the input or cost.
Positive outcome:	- Control of costs	- Control of costs	- High production	- Ability to ward unwanted effects from base model	- Patient focus, economic and professional goals are aligned.
Negative outcome:	- Low productivity - Passing of Patients to other health Care providers - Quality	- Low productivity - Passing of Patients to other health Care providers - Quality	- Poor cost control - Supplier induced demand - Low efficiency	- Patient selection - Conflicting goals outside the system - Manipulation of coding	- Manipulation of coding

Sources: Barnum et al. (1995), Gosden et al. (2001), Calltorp (2009), Jacobsson & Lindvall (2009).

2.2.1 Fixed budget

Fixed reimbursements such as Fixed budget, which is a fixed reimbursement method, provide reimbursement based on for example cost structures and budgets for previous years. It is a simple structure that allows the care givers ample control of expenditures, but it lacks incentives for production and treating chronically or severely ill patients (Lindgren, 2014).

2.2.2 Capitation

Capitation is another fixed reimbursement, based on predefined parameters such as socioeconomics, age or location of the PCC. A set reimbursement is thereby provided depending on the structure of these parameters, implying that the amount or structure of the services provided are irrelevant for the amount of reimbursement. Capitation is the most commonly used reimbursement structure within

primary care in Sweden, today applied in all counties (Lindgren, 2014). This reimbursement type incentives focus on quality and cost containment but can also result in avoiding or passing on complex patients and unfair reimbursement depending on capitation base (Deber et al., 2008; Robinson, 2001; Morris et al., 2012). It is for example argued that capitation might reward denial of appropriate services and passing on or dumping of chronically ill patients (Robinson, 2001).

2.2.3 Fee for Service

Variable reimbursement such as Fee for Service (FFS), is the most commonly used reimbursement structure within healthcare in general (Luft, 2009). The structure is based on reimbursement provided per executed service, often covering most services delivered at a healthcare facility. FFS incentives high productivity and accessibility, but it increase the risk of over-treating, poor collaboration between healthcare facilities, focus on less ill patients and increased healthcare expenditures (Deber et al., 2008; Robinson, 2001; Morris et al., 2012).

2.2.4 Pay for Performance

Pay for Performance (P4P) is another variable reimbursement structure that has become increasingly popular during the last years. The PCCs are reimbursed on specific parameters such as patient satisfaction, quality or health statues of patients. In Sweden approximately 1-40 performance parameters are commonly used why P4P is often implemented as a supplement to other RMs. The aim of P4P is partly to introduce a means of control to manage undesired effects from other RMs, but also to allow decision makers to pin-point rewards for prioritised areas or patient groups such as quality of clinic, satisfied patients or financial measurements. P4P is usually used complementary in combination with other reimbursement models to incentivise specific performance. P4P is debated to be effective in reaching desired outcomes since it also can lead to cherry-picking of patients that bring a high income (Lindgren, 2014).

2.2.5 Value-Based Reimbursement

The value-based RM has been developed to support VBHC and consists of a set of components that must be accomplished for the reimbursement model to become value-based. These components are (Lindgren, 2014):

1. Reimbursement is based on patient-relevant health outcomes
2. No reimbursement for specific activities in the health care chain
3. All operators that can affect the outcome needs to be covered by the reimbursement
4. Costs due to low quality should not be passed on to other operators
5. Reimbursement based on patients' needs so that all patients have access to care regardless of conditions

Reimbursement based on outcome is difficult to implement broadly due to its complexity. Value-based reimbursement is therefor often used in combination with other RMs to increase value and a positive efficiency development (Lindgren, 2014).

2.3 Reimbursement and Innovation

It is thus indicated that the structure of the RM can have a direct effect on how healthcare is organised and delivered, creating different incentives that can affect the efficiency, quality, processes, costs and organisational structure of the care facility (Morris et al., 2012; Lindgren, 2014; Latkovic, 2012). Evidently, the RM can be designed differently depending on what desired behaviour the payers want to enable and trigger. How the primary care is being reimbursed will thereby directly affect how much it will be willing and able to innovate (Frolich et al., 2007). The RM is hence a prerequisite for the possibility and probability of innovation within the care sector (Lindgren, 2014). The effect occurs both through financial opportunity for innovation and through incentives embedded in the RM (Duggan, 2000; Frolich et al., 2007). Through using RMs that emphasise and reward high quality and low cost care, healthcare providers will be incentivised to foster innovation projects aiming to achieve

these outcomes (Luft, 2009) which is a big and complex challenge worldwide (Christensen, 2009; Porter et al., 2013; Latkovic, 2012).

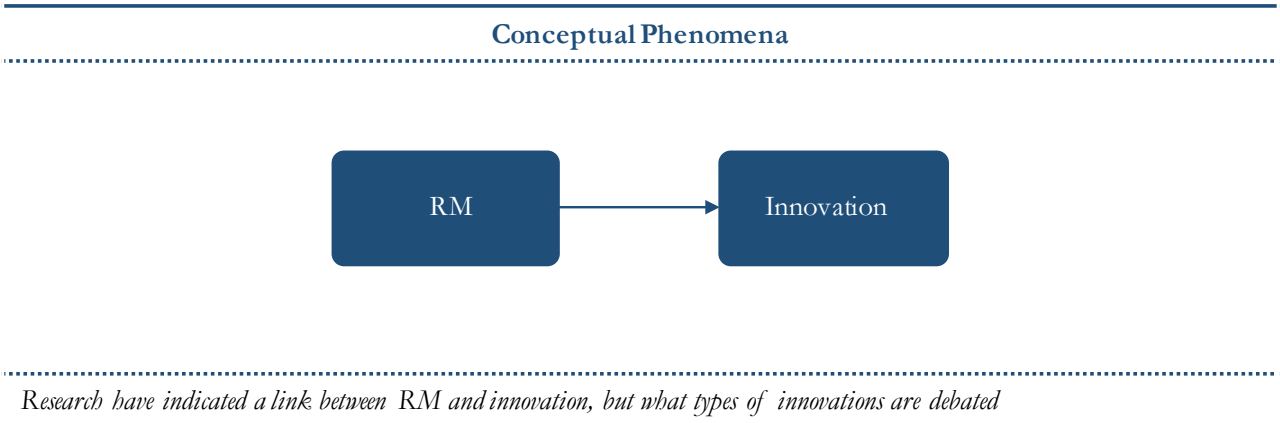
Furthermore is innovation one of the top priorities for healthcare managers and it is seen as a means to integral growth and increase efficiency (Lazarus, 2011). This is done through either minimising the resources spent to reach a given health outcome or through improving the health outcome while being more cost effective. These actions can be incentivised by the structure of the RM (Lindgren, 2014).

However, even though innovation projects are highly appreciated within the healthcare sector, 30-90% of the initiatives fail, which, compared to other industries, is a high rate. This notable fail rate occurs despite the increasing amount of resources and financial support devoted to innovation projects within healthcare and is believed to be due to high economic uncertainty (Jacobs, 2015). Moreover are RMs not developed in the pace needed for incentivising healthcare innovations in a demographically changing society (Krohwinkel, 2015). The economic governance in Sweden is furthermore thought to be too detailed, leaving no or little room for innovative thinking and organisational changes. There is also a scarce development of RMs incentivising innovation projects and todays RMs are often counterproductive since the separate healthcare facilities aim to maximise their own organisation regardless of the consequences for other healthcare facilities (Krohwinkel, 2015). Some researchers states that RMs influenced by VBHC and with a majority of the reimbursement thighed to health outcome increases the possibility and probability for innovation projects (Lindgren, 2014). Still, limited research has been made on what specific innovation incentives the RM can influence (Ellis, 1986) and researchers disagree on which design is the superior in order to achieve innovations aiming at the desired outcomes (Robinson, 2001; Lindgren, 2014). It is therefore necessary to examine and evaluate which reimbursement combinations are the most favourable for the specific care sector and geographical location (Lindgren, 2014).

2.4 Identified Research Gap

Despite the highlighted influence RMs have on healthcare behaviour (Frolich et al., 2007), there is limited research on the link between RMs and innovation. Scholars agree that RMs may influence innovation (Duggan, 2000; Frolich et al., 2007; Lindgren, 2014), see Figure 2.2, but, there is a lack of research on how RMs may trigger innovation, and what type of innovations that may be triggered. As most of the literature focuses on medical and cost outcomes (Ellis, 1986; Lindgren, 2014), many other aspects are ignored. As we have identified, there is no research stating that RMs with certain features will lead to an increase in certain type of innovations.

Figure 2.2 Previous Research



2.5 Analytical Framework

Against the background of the theoretical research gap in the existing literature about reimbursement reforms link to innovation within healthcare, an analytical framework has been developed that builds on theory of: 1. Affordance to conceptualise the link between the RM and organisational innovation incentives and, 2. Innovation theory integrated with BSC in order to conceptualise different types of innovations identified. This is in order to generate propositions of how RMs can influence innovation in primary care.

2.5.1 Affordance

When people encounter objects they see different opportunities and potentials for positive and negative actions and outcomes. To explain these differences, Gibson (1977) presented the concept of *"affordance"*, defined as *"what is offered, provided, or furnished to someone or something by an object"*. Strong et al. (2014) later defined the concept as *"the opportunities people see when they look at objects… affordance is a potential for action"*. Affordances can therefore be seen as a mean to explain how and why certain outcomes occur. It is concluded in four rules: (Strong et al., 2014)

1. Affordances are relational between abilities (PCCs personnel) and environment (RM)
2. Affordances are only possibilities of actions
3. The possibilities of actions are not infinite, it is both enabling and constraining
4. The potential behaviours of an actor are goal directed

Affordances are hence the allowable actions specified by the object or environment coupled with the properties of the individual or group. An affordance is thereby based on what the individual or group does, wants and perceive as useful. Important to note is that affordances only afford further actions, it is not a causal agent of change and consequently it does not trigger or cause the action itself (Van Lier, 2000; Goh et al., 2011; Markus & Silver, 2008).

The concept of affordance was first used within ecological research, but has since been used both to study social interaction, IT systems and healthcare (Van Lier 2000, Strong et al., 2014) and is by Norman (1999) said to be useful and important in all sectors. Example of affordances in organisations can be standardising or coordinating (Strong et al., 2014). New affordances are created as a new system is implemented in an organisation, such as the implementation of an IT-system (Strong et al., 2014) or in our case, a new RM. The importance of understanding affordances becomes evident as one tries to understand why different opportunities and potentials are seen by different individuals or groups and why behaviour differ between them. Affordance can thus be used to investigate what innovation opportunities healthcare personnel perceive that a new RM offers them.

2.5.2 Innovation

2.5.2.1 Background Innovation

Innovation is a well discussed topic and there is almost as many definitions as there are authors (Barnett, 1953; Adams et al., 2006). One of the most famous definition of innovation is from Schumpeter (1912; 1934) who presented five different types of innovations;

1. Introduction of a new good or product
2. Introduction of a new method of production
3. Opening of a new market
4. Acquiring new sources of supply of raw material or semi-finished good
5. Implementation of a new form of organisation

Greenhalgh et al. (2008) has formulated a definition with a healthcare perspective in mind; *"innovation in service delivery and organisation as a novel set of behaviours, routines, and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness, or users' experience and that are implemented by planned and coordinated actions"*. Ergo, innovation is entirely about introducing something new or changing what already exists (Adams et al., 2006). Therefore, it can often be seen through changes in processes, strategies, distribution or marketing (Baregheh, 2009). In this thesis we focus on strategic innovation and process innovation, presented in the section below.

2.5.2.2 Strategic & Process Innovation

Strategic innovation is a fundamental reconceptualisation of what the business does and it occurs when a company identifies a gap in its industry positioning. Gaps can occur due to proactive actions by the company itself as well as through external changes in the business environment. Strategic innovation hence focuses on for *whom* the business is preformed (Markides, 1998). Most strategic innovation projects are influenced by external factors and initiatives from outsiders, (Markides, 1998) such could be regulations and decisions on new RMs (Lindgren, 2014). Strategic innovation is not about just improving the business but rather to re-define the market or the service offered. Notable is that strategic innovation can contain process, organisational as well as other types of innovations (Markides, 1997).

Process innovation is the implementation of a new method, operation or product. The innovation is thereby intended to increase quality, deliver new products or decrease unit cost per delivery, hence increase efficiency. In contrast to strategic innovation, process innovation focuses more on *how* the business is preformed (Markides, 1998). The aim of process innovation in healthcare is to add value or quality to the care service offered (Omachonu, 2010). In healthcare, process innovation is important and improved processes can lead to better patient treatment and save lives. Thereby effective process innovation is highly sought for within healthcare (Jacobs, 2015).

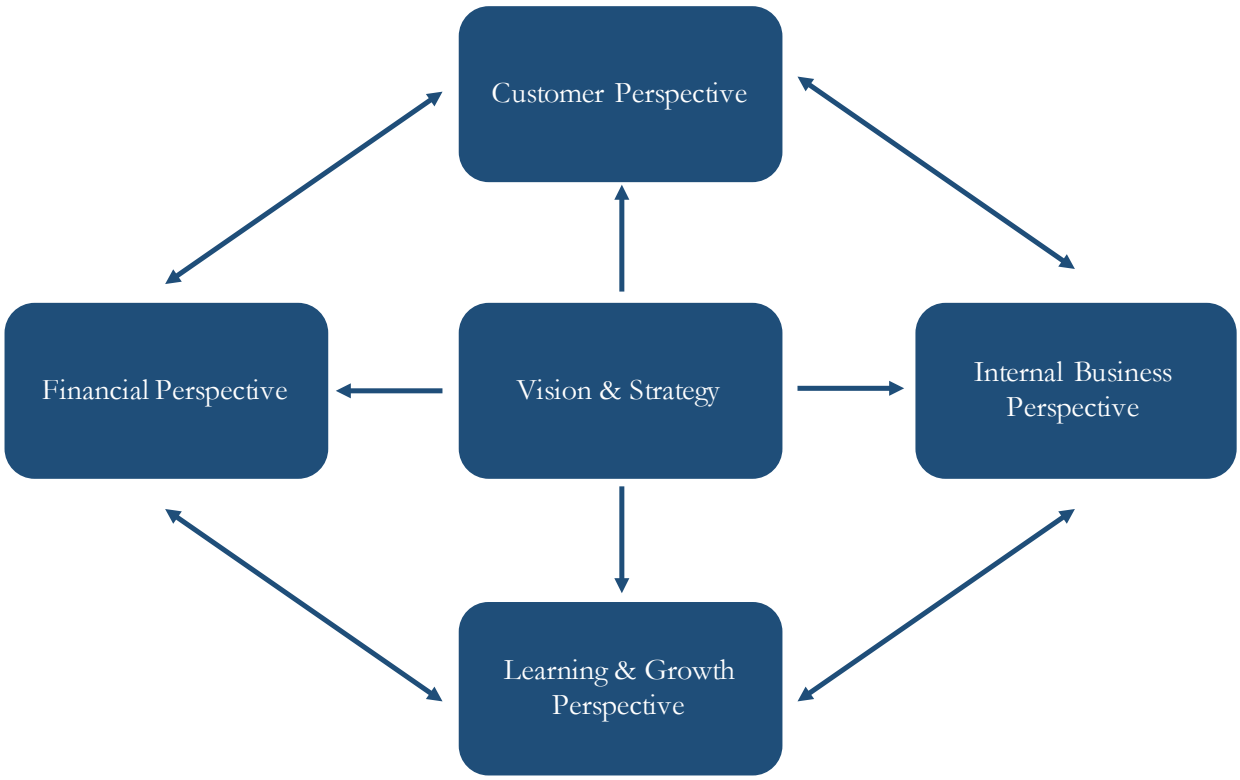
Strategic and process innovations can be either radical or incremental depending on if the change is small or drastic compared to previous organisational activity and focus (Leifer et al., 2000; Adams et al., 2006). Radical innovation is when a completely new product, service or process is developed, in contrast to incremental innovation which rather is continuous improvements of the organisation. Examples of radical innovation can be to explore new technology or create a new market, while incremental innovation is for example future improvements in existing services or products. Incremental innovation is less risky than radical innovation why it often is more popular (Leifer et al., 2000).

2.5.3 Balanced Scorecard

Kaplan and Norton (1992; 1996) have developed a Balanced Scorecard framework (BSC) in order to operationalise the vision and strategy. The model is based on translating the overall vision and strategy into a linked and coherent set of objectives and performance measures to ensure the organisation is moving in the right direction and minimise the risk of sub-optimisation. Kaplan and Norton (1992; 1996) translated the strategy in the following perspectives, also expressed in Figure 2.3 below:

1. Customer Perspective
2. Internal Business Perspective
3. Learning & Growth Perspective
4. Financial Perspective

Figure 2.3 Balanced Scorecard Framework



The balanced scorecard provides a framework to translate strategy into operational terms (Kaplan & Norton, 1996)

The BSC is not only used by profit-driven companies but also within healthcare. Healthcare organisations are recommended to not only look at a single dimension such as financial statements or costs (Castaneda-Mendez, 1996; 1998). The complexity within healthcare require a distinct management tool to make good strategic decisions and evaluate the outcome. The BSC is important to succinctly provide the feedback necessary to help healthcare organisations monitor performance and manage strategy (Voelker et al., 2001). The perspectives mentioned by Kaplan and Norton (1992; 1996) is not literally applicable to all organisations. The essence of the perspectives is relevant but need to be recontextualised to fit the context of application (Voelker et al., 2001). Since there are no generic BSC perspectives defined for the healthcare industry, application of the BSC perspectives have been interpreted by individual actors to fit the context (Voelker et al., 2001; Castaneda-Mendez, 1996). In this thesis we have used the definition of Kaplan and Norton (1992; 1996), informed by the studies in healthcare setting.

Measuring innovation is challenging for most organisations, and it is common for organisations to lack the internal capabilities or not pay attention to the process of innovation management (Kaplan, 1998; Hamel, 1997). However, there is a need for organisations to measure innovation to evaluate whether the innovation efforts have been successful or not, in order to develop innovation capabilities (Ivanov & Silvia, 2014). Innovation projects should be aligned with its strategic objectives and avoid sub-optimisation (Kaplan, 2003; Taylor, 2006). When evaluating innovation projects and measuring innovation variations of the BSC framework have been found effective (Gama et al., 2007; Ivanov & Silvia, 2014).

2.5.3.1 Customer Perspective

Customers are the main reason for existence for any organisation (Kaplan & Norton, 1992; 1996). Healthcare practitioners share this view but choose to refer to it as the *"Patient Perspective"* and are adapting the content thereafter (Castaneda-Mendez, 1996). The customer or patient perspective translate strategy into market- and customer-based objectives. The aim is to capture and improve the

performance of the organisation's offered value proposition for the customers within the targeted market segment (Kaplan & Norton, 1992; 1996). The main categories within the patient perspective mentioned by Castaneda-Mendez (1996), who have applied BSC to a hospital setting, are accessibility, community services, new healthcare services, preventive medicine, clinical outcomes and patient- and family satisfaction.

2.5.3.2 Internal Business Perspective

The Internal Business Perspective is designed to capture the critical processes the organisation must excel at to meet its objectives. The objectives for the Internal Business Perspective is often formulated after objectives for Financial- and Customer Perspectives to operationalise the strategy. The Internal Business Perspective is essentially what the organisation do with focus on how they do it. The focus areas within the Internal Business Perspective are firstly efficiency to timely and consistent deliver services and products to existing customers. The second focus area is to identify market opportunities and design the processes to deliver high value for customers (Kaplan & Norton, 1992; 1996). This perspective is interpreted by Castaneda-Mendez (1996) to rather focus on value-adding objectives for its employees and not how to design the processes for efficient use of resources as Kaplan and Norton do (1992; 1996).

2.5.3.3 Learning & Growth Perspective

Employees are not only important to conduct operational tasks but also for their creativity and ability of constructively challenge existing operations and develop new ideas. The BSC model rests on the assumption that ideas for improving performance for customers and processes must come from the inside of the organisation in order to achieve operational excellence. The BSC highlights the importance to invest for the future, where the Learning & Growth Perspective provide the infrastructure for objectives in the other three perspectives to be achieved. Other dimensions of the Learning & Growth Perspective are motivation and empowerment. (Kaplan & Norton, 1992; 1996). Castaneda-Mendez (1996) has applied the Learning & Growth Perspective to hospitals by focusing on quality improvement, learning-cycle time efficiency and time to develop new services.

2.5.3.4 Financial Perspective

Analysts have argued that a common mistake by organisations is to focus too much on the Financial Perspective and set aside the other perspectives (Kaplan & Norton, 1992; 1996), this is also true for healthcare organisations (Castaneda-Mendez, 1998). Too much pressure on short-term financial objectives cause organisations to reduce allocation of resources on product, process, and human resource development which may affect long-term growth and profitability. There are two main strategic themes within the Financial Perspective. The first is revenue growth which is achieved through expanding services to reach new customers and markets or aiming for a higher-value-added-offerings. The second is productivity improvement to achieve cost reductions (Kaplan & Norton, 1992; 1996). Castaneda-Mendez (1996) highlights these focus areas for hospitals from a financial perspective; activity based costing if feasible, cost-of-quality databases, value-added analyses and other traditional financial objectives.

2.5.3.5 Linking the Perspectives

The four perspectives of the BSC are all linked together and should be used together to operationalise the vision and strategy of the organisation. The perspectives should pervade the same strategy, and can be seen as dimensions to understand the causal chain from strategy, to initiatives, to accomplished strategic goals (Kaplan & Norton, 1996). If the dimensions of the BSC are not synced and linked together, the organisation is unlikely to operationalise the intended strategy and vision (Voelker et al., 2001).

2.6 Summarised Analytical Framework

The analytical framework has been developed to address the identified research gap of the link between RM and innovation, and to add to previous literature by answering aforementioned research question:

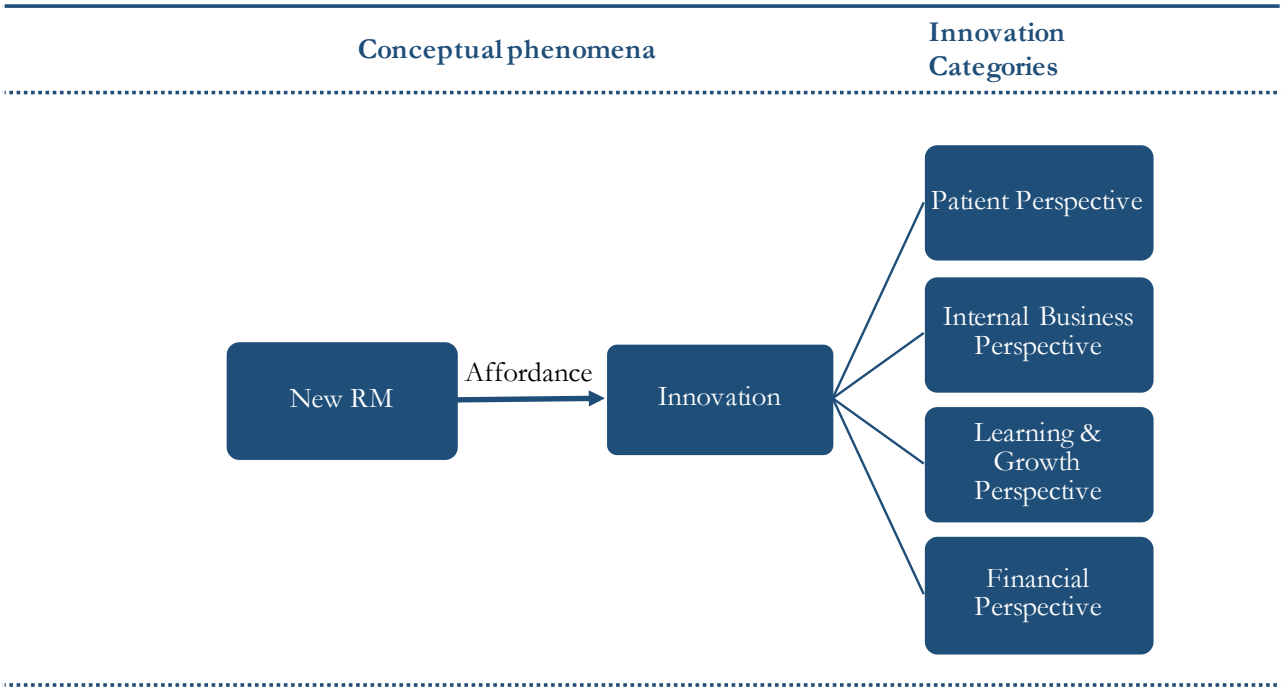
"How does a new reimbursement model with the political intention of improving the quality and efficiency of healthcare afford primary care practitioners to pursue different innovations?"

The affordance literature highlight that people see different opportunities and potentials when encountering an object (Norman, 1999; Strong et al., 2014). Affordance theory can thus be used to analyse how and why certain outcomes occur based on the perception of the object (Strong et al., 2014). Affordance theory is used within healthcare (Van Lier 2000; Strong et al., 2014) but previously not in the context of RMs. The affordance theory will in this study be used in the analytical framework to describe the link between the RM and innovation initiatives, including which parts of the RM have been perceived as opportunities to trigger certain types of innovation initiatives. Innovation theory is used to define and categorise the identified innovation initiatives as strategic or process innovations.

Furthermore, we are applying the BSC, but selectively. We are not applying the BSC in a comprehensive and detailed manner to measure the degree to which a specific strategy has been operationalised. Instead, we are using the multiple dimensions pinpointed by the BSC to critically analyse what target

areas PCCs initiatives are (not) aimed at. The BSC is generally exercised to enable the user to get an overarching view through several dimensions instead of only focusing on specific areas. This multidimensional perspective is valuable when analysing the innovation outcomes that may be triggered through reimbursement reforms. The perspectives of the BSC are in this study viewed as focus areas of innovation initiatives followed from the change in the RM. Figure 2.4 below summarises the analytical framework described above:

Figure 2.4 Analytical Framework



Analytical framework to investigate the link between RM and types of innovations through affordance, categorised through BSC

3. Methodology

This chapter explains the methodological approach used in the thesis. It starts with a section that explains the Research Method, where after we explain the Data Collection. Lastly the Data Analysis and Data quality are presented.

3.1 Research Method

We aim to answer a *"how question"* through a comprehensive explanation within a field with scarce related research. This study does thus exploit a qualitative and explorative multiple case study through an abductive approach.

3.1.1 Research Approach

An abductive analysis builds on both inductive and deductive research approaches. This enables us to both test previous research by addressing a deductive approach and extend previous research by using an inductive approach (Bryman & Bell, 2011; Suddaby, 2006). A deductive approach is suitable when research is already available since it allows the researchers to form expectations about the results before designing the research and collecting data. The researcher often uses hypothesis to test previous theory (Bell, 2006). An inductive approach is useful when there is no previous research in the area. The inductive approach is based on the researchers being open minded since it builds new theory based on the empirical facts (Saunders et al, 2009). Based on previous research, an analytical framework has been developed to test previous research as well as to guide our data collection and analysis. The presented framework has continuously been updated and revised in parallel with the data analysis. The explorative research approach is considered be favourable when previous research is limited, why it is suitable in combination with an abductive approach (Stebbins, 2001; Edmondson & McManus, 2007).

3.1.2 Considerations of Alternative Methods

3.1.2.1 Case Study

There are multiple alternative designs when conducting a research study. All different research designs have advantages and disadvantages and are therefore suitable in different contexts. There are three main aspects to consider when choosing research design (Yin, 2014). Firstly, the form of the research question. Experiment, History and Case Study are the designs that are recommended when using a *"how-question"*. Secondly, it is important to consider whether the study requires control of behavioural events. Experiment design is required when there is a need for control of behavioural events, otherwise it is recommended to choose one of the other two alternatives of designs. However, an Experiment design could also be applied when control of behavioural events is not required. Thirdly, the focus on contemporary events is vital, where either Experiment or Case Study is recommended. When there is a focus on contemporary events, either a Case Study or Experiment is recommended and History could be used when the focus is not on contemporary events. (Yin, 2014). We have chosen a Case Study design since we aim to answer a *"how-question",* and have no need for control of behavioural events and the focus of the study is on contemporary events. There are two types of case study designs; single- or multiple case studies. A multiple case study has advantages over a single case study since it uses several sources and thereby generates more robust data (Yin, 2014). Since the new RM is implemented at four different PCCs, we have chosen to use a multiple case study, considering every PCC as one unit.

3.1.2.2 Qualitative Research

Qualitative research is an increasingly common method for healthcare research (Shortell, 1999; Sofaer, 1999). A qualitative approach is suitable if you want to understand peoples' experiences and their view of the phenomena within the context. It also enables us to give comprehensive explanations and interpret what is happening (Flick, 2009). A quantitative research approach on the other hand enables the researcher to measure the effects of the change and allows generalisation to a larger extent. Quantitative approaches require an extensive and representative sample, predefined variables, and give the participants little flexibility in their answers (Jacobsen, 2002). Qualitative research is one of the

most common methods for collecting data within case studies (Yin, 2014). This study aims to explore how the new value-based inspired RM afforded primary care personnel possibilities to engage in strategic- and process innovation, a qualitative approach is considered preferable.

3.2 Data Collection

3.2.1 Semi-Structured Interviews

A semi-structured interview approach has been chosen since it supports the aim of the qualitative data collection to generate a valuable insight through an exploratory approach. It allows us to better understand how the new RM affects the PCCs beyond previous research and include non-expected issues and experiences (Jacobsen, 2002). Based on previous research on RMs and our framework, we developed a semi-structured interview guide with open ended questions to enable interviewees to answer freely (Jacobsen, 2002). The aim was to develop an interview guide focusing on broader areas rather than to ask too detailed questions, in order to create a flow that enhance the perception of a normal conversation, despite the thorough structure behind. This allows us to follow up the answers in order to develop an in-depth understanding of the subject (Yin, 2007). Semi-structured interviews are the most common way to conduct interviews and improves reliability (Symon, 2012).

3.2.2 Interview Guides

Two interview guides were developed customised to the two interview groups; 1. Employees at the primary PCCs and 2. Initiators of the RM. Both followed the same structure, the difference was that the former included questions regarding the operational effects of the new RM, while the latter focused on the hoped for effects of the new RM. The interview guides can be found in its entirety in Appendix 8.1.

The structure of the interview guides was designed based on previous research in the analytical framework. The interview questions were then defined through a process of brainstorming a long list of possible questions, that could be relevant to ask based on the research question. These questions

were then systematically refined and prioritised to identify the most important, mutually exclusive questions (Flick, 2009).

The interview guides were developed in cooperation with KI and were designed to fit the purposes of both this thesis and their more comprehensive evaluation of the RM. Additional questions were consequently included to the interview guide with the purpose to investigate more practical implications to foster HSF's operations. The structure of the interview guides is presented below.

Before the interview started, we described the background of the project, the open questions structure, and the rights of the interviewee in terms of anonymity and confidentially. The first section of the interview guides consisted of general questions about the interviewee, focusing on describing work and relevant personal history in order to create a relaxed atmosphere where the interviewee felt safe and confident (Jacobsen, 2002). The second section focused on the RM with the aim to capture how the interviewee perceived the RM, attitude towards the changes made and how the work was affected. In the third and fourth sections of the interview guides focus was on innovation, the ability to innovate and the impact of the new RM. The BSC framework by Kaplan and Norton (1996) was used to guide the formation of these questions. The fifth section concerned the innovation process and how well the support by HSF was communicated and received. This was followed by the sixth section where future developments and implementations of the RM was discussed. The fifth- and sixth sections were added to capture practical implications for HSF and not for the purpose of this study. Lastly we completed the interview by asking if there was anything the interviewee wanted to talk more about, if we forgot to ask something, and if he/she could recommend anyone else for us to interview to ensure no important information was missed.

3.2.3 Pilot Interviews

Pilot testing is in many aspects crucial, especially to identify warning signals such as possible flaws and caveats on where the study could fail (Pollitt et al., 2009). It also allows the interviewer to identify possible ambiguities and difficult or leading questions (Peat et al., 2009). In order to assure that we had developed a satisfactory semi-structured interview guide, we thus conducted three pilot interviews, two for the PCC guide and one for the initiator guide. The pilot interviewees for the former guide were made with one department manager at an emergency hospital in Stockholm County and one financial responsible doctor at the same hospital. For the latter guide we interviewed a project manager at HSF. These three interviewees were similar to the actual interview participants in order to make it as real, reliable and representative as possible for the main study.

The pilot interviews helped us with the structure of the questions to assure flow and avoid misinterpretations. It also allowed us to assure that it was possible to conduct the interviews within one hour. Since we were executing a study with professionals under time pressure it was important to keep the time, if no extra time was scheduled or agreed upon. Lastly the pilot tests gave an indication on what type of answers we could expect and how long each question category would take in the main study. This enabled us to allocate our time more efficiently during the main interviews.

3.2.4 Empirical Setting

Kroninnovation was initiated both by HSF as part of an internal, bigger project called "Husläkareprojektet", and externally by the research group MMC at KI and IVBAR, as a Vinnnova project. The Kroninnovation project was consequently first developed as two different projects, one focusing on chronically ill patients and one focusing on innovation. The projects were later integrated into one RM, aiming to support an overarching goal of a more value-based healthcare (Vinnova, 2015; Vårdgivarguiden, 2016). The stakeholders in Kroninnovation are shown in Figure 3.1 below.

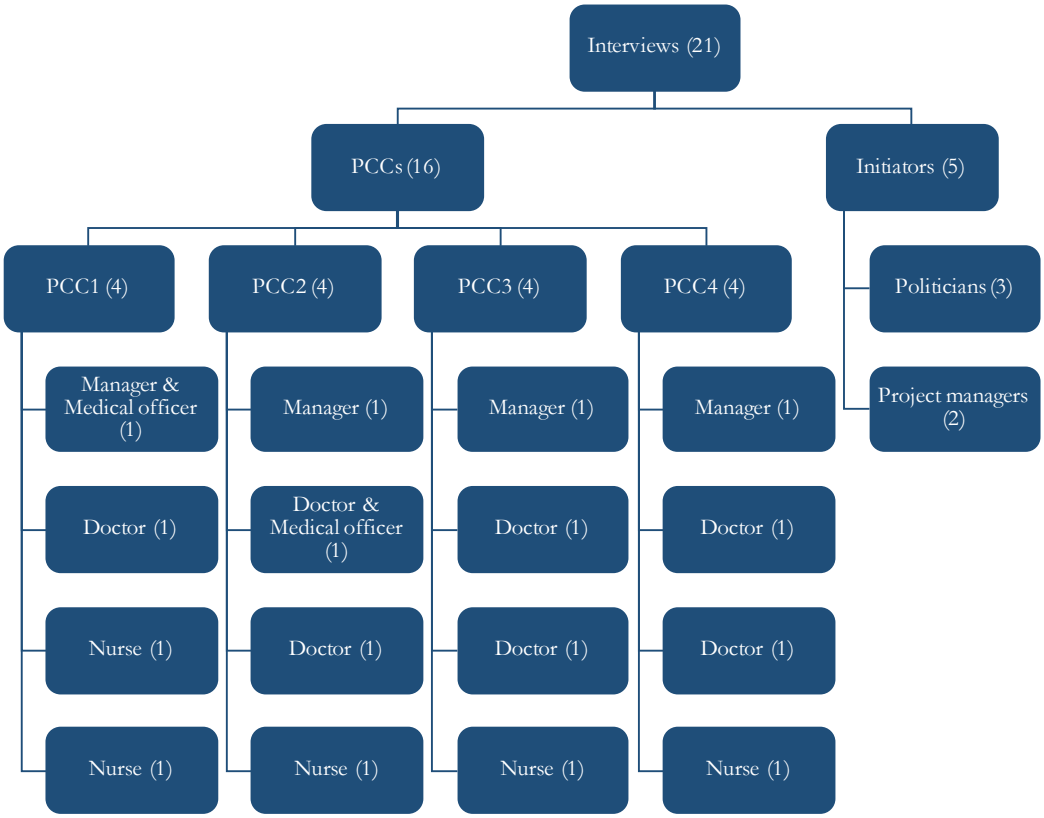
Figure 3.1 Stakeholders of Kroninnovation

Stakeholder	Role of stakeholder
HSF	Initiators of the internal part of the project and support function during implementation
Idérådet	Initiators of the Vinnova project
IVBAR	Initiators of the Vinnova project and evaluators of the Kroninnovation project, both for pre-studies and outcome evaluation
KI	Initiators of the Vinnova project and evaluators of the Kroninnovation project, both for pre-studies and outcome evaluation, this thesis being the first evaluation
PCC	The four PCCs participating in the pilot, randomly selected based on geographical location, all contacted PCCs accepted to participate
SCC	Decision-makers, consist of politicians

3.2.5 Study Participants

Twenty-one interviews were conducted. Twenty interviews are seen as a sufficiently comprehensive amount of interviews since patterns and indications can be clearly identified and understood (Bazeley, 2013; Guest et al., 2006). There are two groups of participants in the study; employees from PCCs (16 interviews) and initiators of Kroninnovation (5 interviews). All categories of participants are listed in Figure 3.2 below.

Figure 3.2 Interview Participants



The figure shows the number of participants in the sample

3.2.5.1 Primary Care Centres

The four PCCs in the participant sampling were chosen as they made up the pilot group of the Kroninnovation project. They are all located in a western suburb of Stockholm, and the difference between them is ownership and the dominant professional group, shown in Figure 3.3 below.

Figure 3.3 Characteristics of the PCCs

Primary Care Centre	Owner Structure	Largest work force	Manager's care giver profession
PCC1	Private	Doctors	Doctors
PCC2	Public	Nurses	Nurses
PCC3	Private	Doctors	Doctors
PCC4	Private	Nurses	Nurses

We contacted the manager at each PCC via email and phone to schedule interviews at their facility with medical officers, doctors and nurses. They were chosen by the manager to ensure that they had at least one-year experience at the PCC. This was the preferred approach since the time schedule is tight at the PCCs and the number of available participants at a given time is limited. The purpose of interviewing healthcare professionals with different background was to get a diversity of viewpoints of the RM.

3.2.5.2 Initiators

To further strengthen our understanding for the project we decided to interview initiators and project managers of Kroninnovation from SCC and HSF. This allowed us to understand the intended, communicated and actual outcome of the project. Thereby enabling us to capture differences both between initiators and PCCs, and within the PCCs.

The group of initiators consisted of three politicians from Sjukvårdslandstingsrådet in SCC. They represented three different political parties and have all been decision-makers of Kroninnovation. The other two interviewees were initiators and project managers behind Kroninnovation at HSF. A total of five politicians were contacted of which three accepted to participate. Only two initiators from HSF were contacted of which both accepted to participate.

3.2.6 Interview Setting

Data was collected between 18th February to 14th April 2016. All interviews were preformed face-to-face at the interviewees' workplace. Most interviews were conducted individually. Although, due to limited availability at the PCCs, some interviews were conducted with two participants at the same time. The average interview took 58 minutes, see Appendix 8.2 for full list with time and dates.

In order to avoid interpretation errors or variations, both researches participated during the majority of the interviews (Eisenhardt, 1989). Though, at some occasions we had to adapt to the time constraints at the PCCs and do parallel interviews. During the majority of the interviews we were also accompanied by the research leaders from MMC, which further diminished the risks of interpretation errors and variations (Eisenhardt, 1989). All interviews were conducted in Swedish since this was the working language for all interviewees.

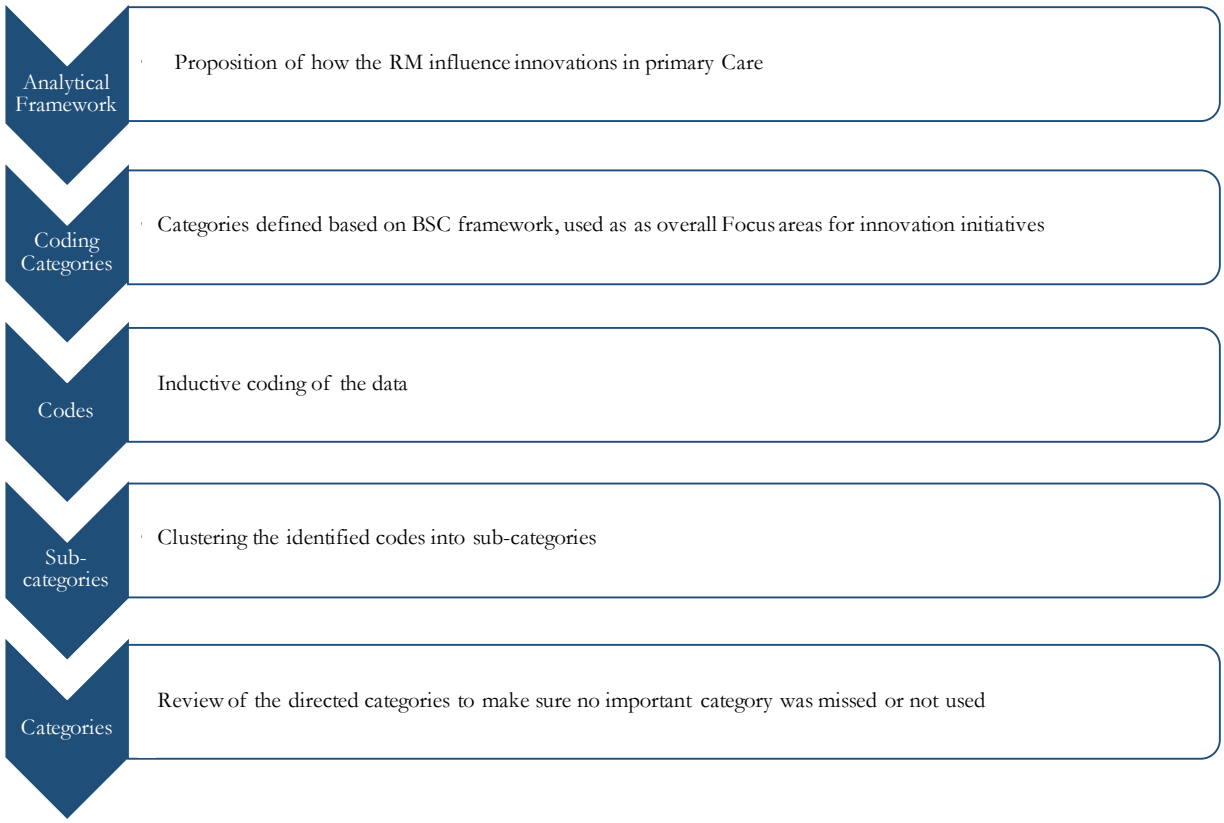
3.3 Data Analysis

There are different approaches for analysing qualitative data. The approaches are similar, aiming to examining materials through breaking it down into small units and submitting them to a descriptive analysis. Thematic analysis is preferred when the researchers want high flexibility, allowing them to expand beyond individual experiences. A content analysis is preferred when there is a big data set of comprehensive content and the aim is to systematically code and categories the findings to identify who says what (Vaismoradi et al., 2013). A directed content analysis is a form of content analysis that takes a deductive starting point and can then be combined with inductive coding to enable new insights to

emerge (Mayring, 2000), allowing us to identify sub-categories as we analyse the content. Using inductive coding is useful when previous research is limited or fragmented (Mayring, 2000) while deductive coding allows us to form expectations based on existing theory (Bell, 2006). A directed content analysis is thereby found suitable for this study. It is also commonly used in healthcare research (Hsieh & Shanon, 2005).

In this study the directed analysis approach is the presented framework that builds on several different concepts to disentangle the relationship between a new RM and innovation through affordance, types of innovations and BSC. This approach is helpful to bring an understanding of the phenomena using a predefined analytical framework, making it useful when developing existing theory (Hsieh & Shanon, 2005). Figure 3.4 below summarises the analysis process through a directed content analysis.

Figure 3.4 Process of Data Analysis



The figure shows a summary of the analytical process

3.3.1 Analytical Framework

The analytical framework was based on the literature review linking RMs, affordance and innovation. This in order to generate propositions of how RMs can influence innovation in primary care. The BSC was used to conceptualise different types of innovation initiatives in order to describe how the PCCs have operationalised the perceived strategy the RM afford.

3.3.2 Coding Categories

The predefined coding categories are the overall perception of what the RM afford and focus areas of innovation initiatives related to the BSC; Patient-, Internal Business-, Learning & Growth- and Financial Perspective. The codebook includes the categories, subcategories and codes, and can be found in Appendix 8.3

3.3.3 Coding

The transcripts were read through to develop familiarity with the data. This enabled us to get an understanding of the content to facilitate the process of coding it (Miles & Huberman, 1994; Morgan, 1993; Morse & Field, 1995). This part of the analysis had inductive approach; the content has been coded based on what the interviewees explicitly said, to minimise the risk of missing important findings (Andersen, 1995; Braun & Clarke, 2006).

3.3.4 Coding Sub-Categories

Organising the codes into sub categories was done to identify meaningful clusters, to reduce the complexity of the content (Coffey & Atkinson, 1996; Patton, 2002). This was a continuous process and involved redefining the sub-categories to ensure that they were mutually exclusive and aligned with the categories of the analytical framework.

3.3.5 Categories

The last part of the coding process was to go through all codes and sub-categories to make sure that no important information had been missed (Bazeley, 2013). When all sub-categories were defined, the predefined categories, overall perception of the RM and the analytical framework were reviewed to make sure the coding categories fitted all identified sub-categories (Hsieh & Shanon, 2005).

3.4 Data Quality

Lincoln and Guba (1985) suggest to assess the quality of qualitative research by evaluating trustworthiness. Trustworthiness is widely used within qualitative research (Bryman & Bell, 2011) is and consist of four criteria's; Credibility, Transferability, Dependability and Confirmability (Lincoln & Guba, 1985).

3.4.1 Credibility

Credibility refers to the internal validity of a research study (Lincoln & Guba, 1985) which addresses if the causal relationship between two variables is properly determined (Yin, 2014). In this study, previous research has suggested there is a relationship between RMs and innovation. To make sure our data have the potential to validate whether this relationship exist and what type of innovations follows from the RM, extensive research has been made to formulate the interview guides to be able to capture and develop these relationships. Three pilot interviews were conducted prior the interview start to ensure the questions were correctly formulated, enabling internal validity (Peat, et al., 2002). It was challenging to determine whether the mentioned innovation initiatives were related to the RM since there are continuous changes within the PCCs. The initiatives the respondents attributed to the new RM are the ones which have been included in the study. Important to note is that even if the respondents' experiences that the RM afforded them new possibilities and inspired them to initiate changes it is not the RM alone that have caused the changes. There are other factors that also could have contributed to the initiated and implemented innovations, such as previous strategies and local agendas (Strong et al., 2014).

3.4.2 Transferability

Lincoln and Guba (1985) refer transferability as the external validity of a research study. External validity concerns whether findings of the study is generalisable and can be applied or transferred beyond the immediate study. Statistical generalisation in this study cannot be made due to the lack of quantitative data (Yin, 2014). To enable generalisability and application of the study to other contexts, four PCCs have been examined in parallel. The multiple case study method has enabled us to not only give example from one PCC but reflect on common reactions to the RM between PCCs. Results also depends on the context. By providing characteristics of the cases, readers can judge if their contexts resemble with the ones studied (Flick, 2009). In order to ensure that the interviewees could speak their mind without withholding any sensitive information, considerations were made, such as anonymous participation with the purpose to create a more relaxed interview. However, we understand that interviewees may still not have spoken their mind for different personal reasons.

3.4.3 Dependability

Dependability of research concerns whether other researchers would come to the same conclusions when using the same data and procedures. Dependability is thereby in many ways similar to reliability (Lincoln & Guba, 1985). The main threat to reliability is that the interpretation of the data is biased and hereby not repeatable by other researchers (Silverman, 2010).

In order to reduce the risk of biased interpretation of the content, all interviews were recorded in consensus with the interviewees. This allowed both researches to take part of the information communicated when both could not participate, to further diminish the risk of misinterpretation and other interpretation errors. At least one interviewer was assigned to take notes during the interviews. This functioned both as a complement to the recordings during the data analysis but also as a support during the interviews to remember what had been said (Symon & Cassell, 2012). All interviews were discussed right after they took place to ensure that both interviewers perceived the information that was communicated in the same way (Symon & Cassell, 2012). To generate better knowledge of what

was communicated during the interviews the recordings were transcribed by the interviewers shortly after they had taken place (Bazeley, 2013).

All coding of the data was done individually and discussed afterwards (Bazeley, 2013). If disagreement occurred discussions was held until consensus was achieved to limit the risk of biased interpretation. The ambition of the methodology chapter of this study was to describe the process of the study in such detail as it can be used as a guide by other experienced researchers to replicate the study (Yin, 2014).

Even though precautions have been made to reduce the risk of biased interpretation of the content, and increase the reliability of the study, biased interpretation may still occur. The interpretation of the content depends to some extent on the researchers' previous experience and insights (Elliot & Timulak, 2005). This should be considered, similar to all other research, when evaluating the reliability of this study.

3.4.4 Conformability

Conformability regards whether the researchers have acted in good faith (Lincoln & Guba, 1985). Lincoln and Guba (1985) argues that researchers cannot truthfully complete full objectivity in business research. By being aware of this issue, we have tried to question whether the interpretation of the results is subjective to attempt objectivity of the research.

3.5 Ethical Considerations

Ethical considerations have been made to protect the participants in the research process. Before each interview the interviewees were informed about what participating in this study meant for them, that participation is voluntarily and that they were free to leave the interview whenever they liked. The participants have also been given the option to accept or reject to be recorded during the interview, fulfilling the criteria for consent (Loue, 2000). Furthermore, none on the participants were subject to coercion since they were deemed to have an understanding for what participation implied for them, but important to highlight is that they were asked to participate by their managers why some inclination to accept may have occurred.

All information was handled confidentiality, only the research group had access to the material and all material were deleted after finalisation of the study. The recordings were transcribed shortly after the interviews and data was stored in a cloud function, before it was deleted. As the data was analysed the participant names were coded to a number and letter for succeeding communication. These precautions were made to minimise the risk of negative consequences for the participating subjects (Loue, 2000). The ethical approval number of this study is *2014/2042-32*.

4. Empirical Results

The following chapter describes the empirical findings from the political initiators and the four PCCs. A table of all interviewees can be found in Appendix 8.2. The findings for initiators are structured in accordance with the sub-categories identified in the data analysis. For PCC the empirical findings are structured based on their Perception of the RM, and thereafter in accordance with the BSC; 1. Patient Perspective, 2. Internal Business Perspective, 3. Learning & Growth Perspective and 4. Financial Perspective.

4.1 Initiators

A holistic presentation of the empirical findings for initiators is presented in order to ensure understanding of what the intentions with the new RM was, compared to the actual outcome.

4.1.1 Create More Value for Patients

All initiators stressed that the new RM emphasise the importance to focus on elderly, chronically ill and multi-sick patients. It was also emphasised by some interviewees that the new RM allows care givers to focus more on proactive care and self-care. Fewer and longer appointments were mentioned as an expected outcome of the new RM, allowing care givers to take care of more issues during one appointment rather than booking an excessive amount of appointments, which was said to be done in the previous system. Nevertheless, concerns were also raised regarding decreased accessibility since reimbursement is not given per appointment to the same extent as previously.

"The new RM implies more time for each patient. There is no point in avoiding patients in need of a lot of care anymore." - Int_2_HSF

4.1.2 Changes in Allocation of Resources

A better balance between primary care professions was expected by all initiators as a response to the new RM. It was furthered underlined that the level of stress for both nurses and doctors were thought

to be affected positively since nurses are encouraged to take more responsibility for more advanced patient focused tasks. Moreover, this was believed to further ensure good patient accessibility.

"In essence it's about finding the person who is best suited for providing the care needed. They are good at working in teams at the PCC and if we give them the power to figure out how themselves they will solve it in the best possible way. I'm sure of it." - Int_3_SCC

"Hopefully they will find other and better ways to work than just focusing on doctor appointments. They can have more cross-professional groups." - Int_4_SCC

4.1.3 Increased Freedom to Innovate

An overarching goal with the new RM was said to be increased freedom for care givers to execute innovation initiatives aiming to improve the quality of care for patients. Managers were expected to assume main responsibility for encouraging innovation initiatives and development ideas. All personnel were also expected to be responsible for coming up with and executing changes at the PCCs.

"The aim is to increase the freedom for healthcare professionals to adapt their care activities to attend to the needs of the citizens. By having less details and less administration in the RM, we hope to increase their capability to innovate." - Int_1_HSF

However, no clear visualisation of how the PCCs are to adapt and work with the new RM was presented. Few initiators expressed clear visions of what innovation initiatives they expect to identify, but it was emphasised that some kind of evaluation of the projects would be advantageous.

"Imagine if politicians thought about the causal chain, it would be much better." - Int_5_SCC

Figure, 4.1, below summarise the main perception of the purpose of the RM by the initiators, identified in four categories.

Figure 4.1 Initiators Perception of New RM

Sub-category of perception	Perception	Initiators
Attitude toward RM	*Positive*	
Increase Quality of Care	*Chronically ill, elderly and multi-sick patients*	
Allocation of Resources	*More responsibility for nurses*	
Freedom to Innovate	*Increased freedom to innovate*	

Green icon indicate identified perception of RM

4.2 Primary Care Centres

All PCCs had a majority of interviewees stating a positive attitude toward the new RM. They believed it to be a step in the right direction, even though it was emphasised that the structure could be improved. For example, some interviewees mentioned that they would prefer a RM with reimbursement for psychological appointments and interpreter or reimbursement based on measurements for quality. All PCCs agreed that the design of the new RM is aligned with the official purpose, to give the PCCs more freedom to increase quality. Though, the increased freedom was never mentioned by the interviewees themselves but rather agreed upon when asked. In Figure 4.2 on following page, one quote from each PCC have been chosen to describe how they perceived the new RM.

Figure 4.2 Perception of RM

Primary Care Centre	Perception
PCC1	*"Before the new RM we had a greater focus on having many appointments. Now we are being compensated for the listed patients, why we can focus more on the actual care provided"* - Int_9_N1
PCC2	*"So I welcome this new RM very much. It is more ethical and moral. Now we will be able to care for the patients in greater need of care better."* - Int_10_M2
PCC3	*"It has been unfortunate that only doctors have been viewed as important in primary care. The skills and competence of nurses might have been unutilised in previous RM. With the previous RM we also did some unnecessary car. Unnecessary appointments.... Which is not needed with the new RM."* - Int_14_M3
PCC4	*"I hope that the aim is to make it less appointment focused. This will allow us to have more focus on self-care and counselling, providing higher quality in care for those in need of it and skip unnecessary appointments."* - Int_21_N4

Quotations from all PCCs on perception of the new RM

Almost all interviewees perceived the RM to enable increased responsibility for nurses. Furthermore, all PCCs addressed that the needs of multi-sick, chronically ill or elderly patients as a group will gain more focus in initiatives taken based on the new RM. The increased fixed reimbursement was said to lead to an overall increased focus on care and quality at all four PCCs.

"We experienced often that those who are not so sick took a lot of time from those who are actually sick. It was more encouraged to take quick visits with patients that are not so ill. in long run, this is not sustainable." - Int_16_D3

Focusing on how the PCCs had started to take actions to adapt to the new RM, it is evident that mostly managers were engaged in the innovation process. Overall at the four PCCs managers were the most positive and aware of the changes that had been made and that are to be implemented. Even though the PCCs were already showing some results on innovation initiatives, it was stressed that no crucial changes had been or will be made at the moment. There was a perceived uncertainty of how long the new RM will be in force and there was a fear of changing the PCC too much if the RM is only

temporary. Moreover, PCC1 and PCC3 were highly equipped for the old RM, both in personnel and processes, which created difficulties in changing the business quickly.

"We don't have an education in how to structure a business. And the directives from SCC change all the time. It feels like we are happy amateurs, trying our best without any structured support." - Int_15_D3

"There are uncertainties how it will be 2017. We do not know how it is going to be. If the KVÅ- codes will be back in 2017, we do not want to lose those routines this year" - Int_18_M4

The Figure 4.3 below have listed the overall perception of the RM for each PCC.

Figure 4.3 PCCs Perception of New RM

Sub-category of perception	Perception	PCC1	PCC2	PCC3	PCC4
Attitude toward RM	*Positive*				
Increase Quality of Care	*Chronically ill, elderly and multi-sick patients*				
Allocation of Resources	*More responsibility for nurses*				
Freedom to Innovate	*Increased freedom to innovate*				

Green icons indicate identified perception of RM, grey icons indicate not identified perception of RM

4.2.1 Innovation Patient Perspective

The patient perspective is defined as innovation initiatives to improve the quality for patients. It is summarised in the three following sub-categories: 1. New processes for accessibility, 2. New processes for proactive care and 3. New processes for self-care.

4.2.1.1 New Processes for Accessibility

New processes for accessibility concerns new processes that affect how easy it is for patients to get care, compared to when the old RM was used. The patient accessibility was by all interviewees thought to be a major component in the new RM. Focus on having the patient in mind was now said to be necessary in order to assure increased accessibility and thereby create greater incentives for the patients to stay listed at the specific care centre. All PCCs highlighted that chronically ill, elderly and multi sick patients would be extra prioritised for accessibility innovations since the fixed reimbursement is higher for more ill patients. As the innovation initiatives mentioned differ, each PCC is presented by itself.

"Now we focus more on how we as a primary care centre can be accessible in different ways to the patient" - Int_6_M1

"There is a greater focus on the actual care provided and you can already see that the patients are a little bit more satisfied." - Int_9_N1

All PCC had initiated at least one innovation initiative to increase or maintain good accessibility. At PCC1 three innovation initiatives concerning accessibility had been implemented; a drop-in reception for infectious diseases, video appointments and increased home care to every second Tuesday.

"The first video appointment is already booked. It is with a patient that goes to USA for a longer vacation, but who still needs a follow-up on the medications proscribed." - Int_6_N1

At PCC2 one innovation initiative had been implemented; expansion of the telephone consultation service with one extra nurse. This allowed the nurse to handle less acute situations via telephone rather than to book new doctor appointments, to avoid *"unnecessary"* appointments. This is expected to decrease *"unnecessary"* appointments, the waiting time for patients and work-load for doctors. The PCC was also expecting to implement video appointments and increased home care soon.

"We have some nurses operating our hot-line, however, I am extending this service by adding another nurse to the team. The aim is that they will be able to take care of emergency patients with non-acute conditions, such as caring for simple wounds or irritated skin, instead of directly booking doctor appointments." - Int_10_M2

At PCC3 three innovation initiatives related to patient accessibility had been undertaken. The first project had been to shut down the drop-in reception since there was no financial sustainability or possibility to keep it based on the structure of the new RM as quick appointments with relatively healthy patients is not rewarded. This was explained as to lead to decreased accessibility since it made it more difficult for patients to get an appointment. The second project was a response to the closed drop-in reception, a new e-booking/e-access service for patients, allowing them to effectively book appointments before visiting the PCC and thereby minimise the waiting. To care for elderly patients unable to use the new e-booking, one extra nurse was added to the hot-line team. The third initiative concerned increased home care since the reimbursement for this service is significantly higher compared to regular appointments in the new RM. Furthermore, video appointments were expected to be implemented later.

"*I told you about the drop-in reception, we closed it and are now using an e-booking system instead. It would not have been possible to close it if it was not for the new RM."*- Int_14_M3

"We have to use our recourses efficiently, in the right way to survive financially. This is therefore a thing that we are going to do, primary care focused on home care." - Int_14_M3

PCC4 had focused their accessibility innovations on eased communication between patient and care personnel and more accessible information for patients. One innovation project had been implemented; extended telephone service with one extra nurse to be more accessible and assess early if patients need to see a doctor or not in order to avoid *"unnecessary"* appointments. The PCC expected to

implement digital forms for patient symptoms, extended communication to text messages, contact forms via e-mail and video appointments later.

"Chronically ill patients and those who visits us often will hopefully notice the difference. We have made it easier for them to get back to their regular doctor, even when they come in acute." - Int_20_D4

However, both PCC1 and PCC3 expressed concerns about decreased accessibility due to lower incentives to schedule doctor appointments as these are not as profitable in the new RM as in the old. It was also mentioned that the perceived accessibility by patients could be affected negatively if patient only considered doctor appointments as a measure of accessibility and not the offered service as a whole, why appointment with nurses would not be appreciated. It was moreover debated that the accessibility might decrease for patients with lighter diseases and increase for chronically ill patients with a more extensive need of care, since it is more profitable to have many severely ill patients.

"If we decrease the amount of doctor appointments due to the decreased incentives for them, the accessibility will decrease. But on the other hand the quality of the appointments might be improved." - Int_8_N1

Figure 4.4 below shows initiatives taken regarding New Processes for Accessibility at each PCC.

Figure 4.4 New Processes for Accessibility

Sub-category of initiative	Initiative	PCC1	PCC2	PCC3	PCC4
New Processes for Accessibility	*Clinics*				
	Telephone/Operating/Booking system				
	Video Appointments				
	Extended communication methods				
	Home Care				

Green icon indicates implemented positive innovation initiative, red icon indicates implemented innovation that decreases the accessibility, yellow icon indicates defined, but not implemented initiative, grey icon indicates no innovation initiative.

4.2.1.2 New Processes for Proactive Care Services

Proactive care concerns care that is given to prevent or postpone the need of more severe and recourse intense care services. The use of proactive care was highlighted as important by one of the four PCCs. Since the new RM allows the PCCs to allocate recourses differently, one mentioned possibility was to put more attention on proactive care in order to increase quality and maintain listed patients.

Two innovation initiatives had been implemented at PCC1. The first initiative was to increase the use of life-style meetings offered by nurses to discuss habits and healthy living with patients. The second initiative was the implementation of new processes for renewing prescriptions. As opposed to before, the patients were no longer encouraged to call in to the PCC to re-new their prescriptions, but rather to book a meeting and review the drugs taken, and the effects they have on each other and the patient. This in order to prevent medication errors in prescription renewals.

"Previously we have not had the resources to have these personal meetings when it comes prescription renewals. Even though we just initiated the project with more meetings and follow up discussions there are several patients who finds it great!" - Int_8_N1

Figure 4.5 below shows initiatives taken regarding New Processes for Proactive Care at each PCC.

Figure 4.5 New Processes for Proactive Care

Sub-category of initiative	Initiative	PCC1	PCC2	PCC3	PCC4
New Processes for Proactive Care	*Prescription renewal*				
	Life-style clinic				

Green icon indicates implemented positive innovation initiative, yellow icon indicates defined, but not implemented initiative, grey icon indicates no innovation initiative.

4.2.1.3 New Processes for Self-Care

Two out of four PCCs mentioned increased focus on self-care as a possible initiative. Yet, only one mentioned a new, concrete action that had been implemented. PCC4 had implemented increased telephone time with nurses informing about self-care. They did also discuss to implement patient self-care education. At PCC3 the importance of self-care was only highlighted.

"With the old RM it was useless to focus on patient education. Now, with the new RM, we are able to have patient education with focus on their own healthcare producers. Now we have time. We're working on it." - Int_17_M4

"I hope that the new RM intends to not focus as much on patient visits as the old one did. So we can focus much more on the patient's own care and counselling. It allows us to have higher quality on the visits since we can skip 'unnecessary appointments'. Before we didn't want to give patients counselling but rather have the patients coming in for a visit, in order to get our compensation." - Int_21_N4

Figure 4.6 below shows initiatives taken regarding New Processes for Self-Care at each PCC.

Figure 4.X New Processes for Self-Care

Sub-category of initiative	Initiative	PCC1	PCC2	PCC3	PCC4
New Processes for Self-Care	*Telephone education*				
	Patient education				

Green icon indicates implemented positive innovation initiative, yellow icon indicates defined, but not implemented initiative, grey icon indicates no innovation initiative.

4.2.2 Innovation Internal Business Perspective:

The innovation initiatives that had been made regarding the internal business perspective are summarised in the two following sub-categories: 1. Redesigned processes around nurses, 2. New processes for teamwork. All interviewees emphasised the importance of initiatives undertaken in both sub-categories.

4.2.2.1 Redesigned Processes Around Nurses

The new RM implies an increased reimbursement for services provided by nurses, which have resulted in all PCCs at least discussing initiatives concerning increased responsibility for this profession. All interviewees at all PCCs agreed that this gives incentives to increase the processes around responsibility and power of nurses.

"For the future we are aiming to not only have doctors working at the drop-in clinic for infectious diseases, but also nurses, who can assess some patients by themselves." - Int_6_M1

All PCCs mentioned nurse-led clinics as a possible response to providing more responsibility for nurses. Two PCCs had implemented such a clinic, the others discussed it as future innovation projects. At PCC1 the new infection clinic was nurse-led with nurses making the first assessment of all patients. Furthermore, they discussed the opening of a new blood pressure clinic that would be nurse-led.

"We are aiming to not only have doctors working at the drop-in clinic for infectious diseases, but also nurses, who can assess some patients by themselves." - Int_6_M1

PCC2 is a nurse-led PCC why focus on nurse-led clinics, such as diabetes and blood pressure, already existed and no major changes had been made. Nonetheless, it was mentioned that even more responsibility was to be put on nurses and the opening of more nurse-led clinics were discussed in order to ensure that doctors can focus more on complex cases, increasing the process of working in consultancy-like teams. Important to note though is that no innovation initiatives had been made within this category yet.

"I have already noticed that I am more interested in hiring more nurses. As nurses got higher statues they have also blossomed. They are coming with more ideas and want to take more responsibility. They are growing as a group and I find that positive." - Int_10_M2

At PCC3 the care competence of nurses was described as unutilised in the old RM and one initiative had been taken to utilise their competence better. Changes had been made in the time scheduling system in order to open up the schedule for nurses more and thereby enable them to care more for patients. PCC3 did also, just as PCC1 and PCC4 discuss the increased incentives to open new nurse-led clinics such as a diabetic clinic, blood pressure clinic and hypothermia clinic. This would allow doctors to function as consultants focusing on more complex patients, albeit none of them were opened yet.

"Hm... Well and then... Well we haven't really. We planned to open a blood pressure clinic but now we are more looking at a varan clinic. But we have just started so it's hard to say. We are also discussing a diabetes clinic led by nurses but I don't know. There are plenty of ideas but we haven't done so much yet." - Int_17_N3

PCC4 mentioned an overall focus on nurse-led clinics for future innovation initiatives, due to the new RM they had recently started a nurse-led blood pressure clinic.

"It is maybe two weeks ago that we started with the 24-hour blood pressure, it is led by three nurses." - Int_18_M4

"Nurses can make a first assessment of the patients to decide whether they have to meet a doctor or not. In that way they can prevent unnecessary visits. Nurses work as a filter before any further care is given." - Int_19_D4

Figure 4.7 below shows initiatives taken regarding Redesigned Processes around Nurses at each PCC.

Figure 4.7 Redesigned Processes around Nurses

Sub-category of initiative	Initiative	PCC1	PCC2	PCC3	PCC4
Redesigned Processes around Nurses	*Nurses responsible for new/more clinics*				
	Time-scheduling				

Green icon indicates implemented positive innovation initiative, yellow icon indicates defined, but not implemented initiative, grey icon indicates no innovation initiative.

4.2.2.2 New Processes for Teamwork

The increased responsibility for nurses had resulted in an increased willingness and necessity to collaborate and improve the teamwork between the professions at the PCCs. The new innovation initiatives that had been executed or are to be implemented requires improved teamwork, but only one PCC had implemented new processes for this. It was also highlighted by some interviewees that teamwork in general is an area in great need of improvement within primary care.

"Surprisingly enough, collaboration and teamwork is not functioning properly in the healthcare sector. It's probably because nurses are often seen as assistants to the doctors. We must try to encourage and lift them in order for them to understand that they can handle more duties themselves." - Int_5_M1

All four PCCs highlighted the importance of increased teamwork in order to provide more responsibility for nurses. Doctors were described to possess a position more as a consultant and nurses were to be given more patient contact, but only PCC1 mentioned that they were working with teamwork actively at their new infection clinic through cross-professional teams.

"At the new drop-in infection clinic, we work in teams where the function of the doctor is more like a consultant to the nurses that provide most of the actual care." - Int_8_N1

"We have a very talented healthcare team consisting of nurses. When it comes to diabetes care I almost do not dare to treat someone without consulting the nurses first. The more specialist nurses we have the better for the patient."

- Int_11_D2

The increased focus on nurses and teamwork creates opportunities for better working conditions since nurses can take care of more patients, allowing doctors to have longer appointments with more complex patients. Even though they highlighted that the RM is new and they had not fully adopted to

the changes anticipated yet, hopes were raised concerning the working conditions for both nurses and doctors.

"We have not made any major changes yet in response to the new RM, and I do not think it will change the way we are working significantly. However, work satisfaction is significantly improved already." - Int_6_M1

Figure 4.8 below shows initiatives taken regarding New Processes for Teamwork at each PCC.

Figure 4.8 New Processes for Teamwork

Sub-category of initiative	Initiative	PCC1	PCC2	PCC3	PCC4
New Processes for Teamwork	*Cross-professional teams*				

Green icon indicates implemented positive innovation initiative, yellow icon indicates defined, but not implemented initiative, grey icon indicates no innovation initiative.

4.2.3 Innovation Learning & Growth Perspective

The innovation initiatives that had been made regarding the Learning & Growth perspective are summarised in the two following sub-categories: 1. New processes for transferring knowledge and 2. New processes for developments.

4.2.3.1 New Processes for Transferring Knowledge

As the new RM afford increased responsibility for nurses a need for transferring knowledge from doctors to nurses in order to ensure safe and effective care delivery was identified. Three out of four PCCs agreed that nurses are to successively be taught by doctors in order to be able to assume more responsibility within several fields. The fourth PCC expressed no major thoughts on the subject.

"Nurses claim that in order to be able to take more responsibility, they need more training. And of course we will provide this. We are gradually trying to transfer knowledge from doctors to nurses to make it clear and understandable."

- Int_6_M1

In order to transfer knowledge successfully, doctors are to function as consultants, teaching nurses relevant information for treating patients. They did also discuss to implement development processes where doctors present processes to transfer knowledge.

"We have a team that focuses on development processes where doctors gradually educate nurses to execute multiple tasks themselves. " - Int_6_M1

At PCC2 and PCC3 nurses were encouraged to take more responsibility, although no specific initiatives to ensure this was mentioned. At PCC4 instructions and manuals were written by doctors for nurses to follow in treatment of patients. This in order to make them more secure in their patient care and enable them to take more responsibility.

"I made a summarising manual for nurses to follow. It's maybe four pages, focusing on how they should deal with patients with different skin changes. They can use this manual in order to take more and better decisions and thereby become more independent. But it has to be straightforward and not too complicated." - Int_20_D4

Only one interviewee disagreed with the others, the interviewee stated that nurses are not interested in more responsibility and knowledge why this initiative is *"unnecessary"*.

"Nurses don't want to take any responsibility." - Int_7_D1

Figure 4.9 shows initiatives taken regarding New Processes for Transferring Knowledge at each PCC.

Figure 4.9 New Processes for Transferring Knowledge

Sub-category of initiative	Initiative	PCC1	PCC2	PCC3	PCC4
New Processes for Transferring Knowledge	*Doctors as consultants*				
	Process development				
	Instructions and manuals				

Green icon indicates implemented positive innovation initiative, yellow icon indicates defined, but not implemented initiative, grey icon indicates no innovation initiative.

4.2.3.2 New Processes for Development

Regarding time for innovation ideas the interviewees at the four PCCs had different opinions. PCC2 did not mention this sub-category at all. PCC3 mentioned it as important, the entire PCC has to be restructured and knowledge must be transferred not only between doctors and nurses but also between several different departments and professions. Despite this, no concrete innovation project to ensure this was mentioned.

At PCC1 cross-functional working groups had been launched in order to ensure discussion and promote new ideas and initiatives about how to improve the organisation.

"We have launched permanent working groups with members from each professional category in every group. They are encouraged to brainstorm freely about how we can change our approach. We have already defined a number of areas of improvement that we are now working with." - Int_6_M1

PCC4 had not implemented any initiative yet, but study visits at the different clinics within the PCC was mentioned in order to ensure that the different professions learn from each other and get inspired to new innovation projects.

"*Yes, we do what suits us. If it doesn't work, stop and try something different. We are bold and we dare to try new things. People here are flexible and I think that's the key to new ideas and development. People have ideas, we try, we meet half way."* - Int_18_M4

However, light was also shed upon the increased stress in the profession and how focus was no longer on providing understandable service to the patient but rather to execute given directives from top level decision-makers. Focusing on innovative ideas was mentioned as further increasing the stress amongst both doctors and nurses.

"Now I only have time to follow up programs, we execute the directives communicated from the top down to the organisation." - Int_7_D1

Figure 4.10 below shows initiatives taken regarding New Processes for Development at each PCC.

Figure 4.10 New Processes for Development

Sub-category of initiative	Initiative	PCC1	PCC2	PCC3	PCC4
New Processes for Development	*Cross-functional working groups*				
	Study-visits				

Green icon indicates implemented positive innovation initiative, yellow icon indicates defined, but not implemented initiative, grey icon indicates no innovation initiative.

4.2.4 Innovation Financial Perspective

For innovation initiatives concerning financial perspectives, few projects could be identified. Only one possible innovation initiative has been highlighted, this is discussed in the sub-category: 1. Changed focused regarding appointments.

4.2.4.1 Changed Focus Regarding Appointments

Regarding the financial focus, it was mostly managers that could express an opinion since most of the other interviewees did not have any insight in the subject. Even so, almost all interviewees mentioned less focus on many short appointments as an important change done with the new RM, at least once during their interview.

All PCCs did therefore agree that less focus on maximising the number of appointments were important in the new RM. This resulted according to many in a feeling of increased safety and decreased stress. It was said to allow the care givers to attend patients in real need of care without jeopardising the budget, using doctors and nurses in an effective way in order to provide the best care possible but still ensure reimbursement. At PCC1 it was also highlighted that the new RM facilitates the process of making and follow up on budgets.

"We should not maximise the number of appointments. Instead we should work more long-term... Since the reimbursement for doctor appointments today are lower, there is no incentive to have as many doctor appointments as before... Patients should become more satisfied and get better quality. They should feel that we care about our patients."

- Int_9_N1

"In the previous system, all we talked about was quick, short appointments with healthy patients, 'the healthier patients, the more profitable'." - Int_10_M2

Figure 4.11 below shows initiatives taken for Changed Focus Regarding Appointments at each PCC.

Figure 4.11 Changed Focused Regarding Appointments

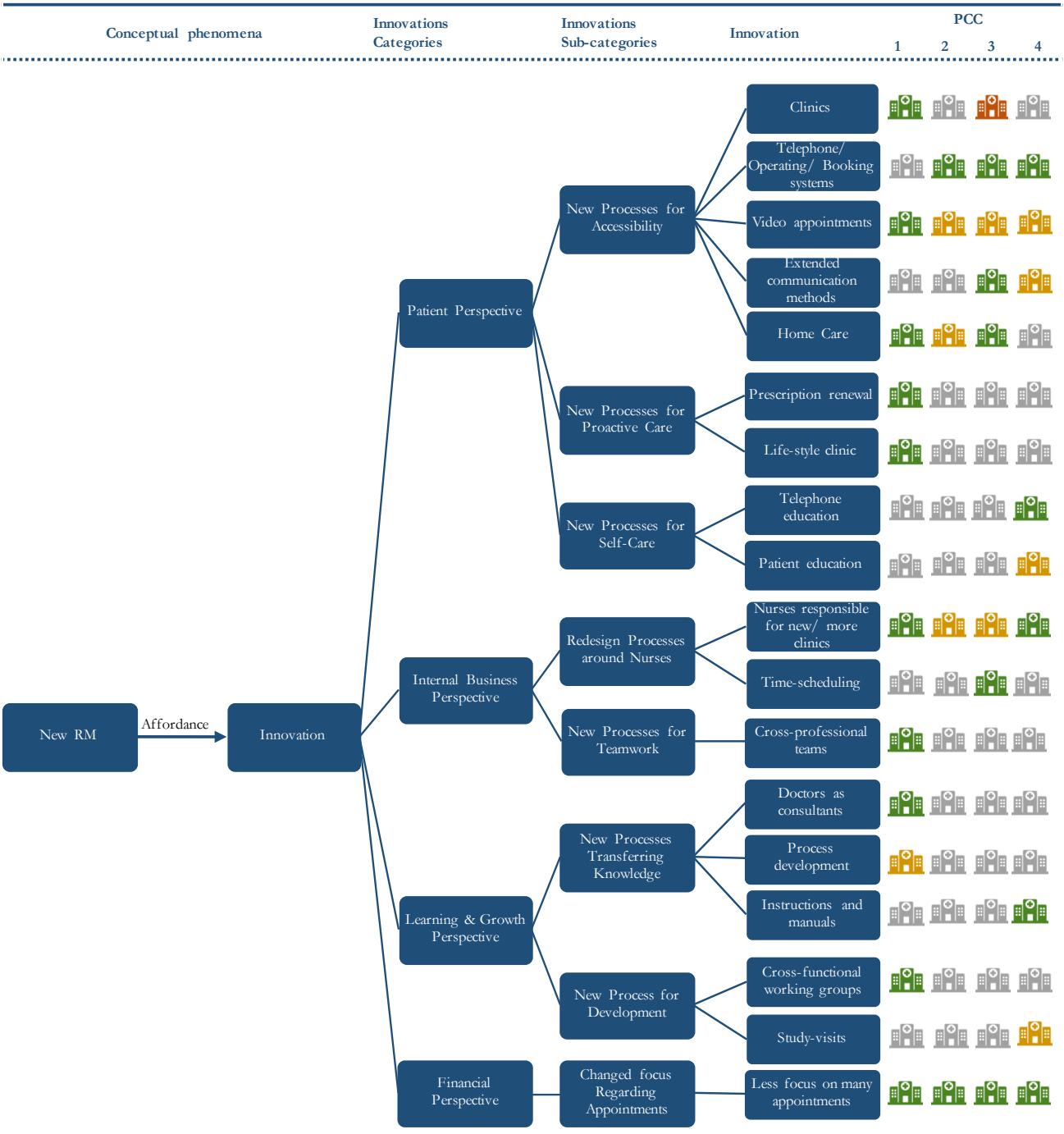
Sub-category of initiative	Initiative	PCC1	PCC2	PCC3	PCC4
Changed Focus Regarding Appointments	*Less focus on many appointments*				

Green icon indicates implemented positive innovation initiative, yellow icon indicates defined, but not implemented initiative, grey icon indicates no innovation initiative.

4.3 Summary of Innovation Initiatives from Empirical Findings

The Figure 4.12 below is a further development of the analytical framework and summarises what type of innovation initiatives that have been identified among the PCCs, both ideas and implemented projects.

4.12 Analytical Framework and Summary of Empirical Results



The grey icons indicate that no innovation initiative have been identified. The green icons indicate that innovation initiatives have been implemented. Orange icons indicate initiated but not implemented innovation initiatives. The red icon indicates that innovations have been identified which decrease accessibility.

5. Analysis

In the following chapter an analysis of the empirical findings will be presented. First we introduce a section on Innovation, which is followed by the Role of Context. Thereafter an analysis on the design of the RM follows, ending with how the different perspectives of the BSC are interlinked.

All PCCs highlighted the increased quality of care as they described the purpose of the RM, mentioning that it afforded them to change focus to elderly, chronically ill and multi-sick patients, compared to less sick patients. All PCCs have a positive attitude toward this purpose and have initiated a number of innovation initiatives identified to work towards the aforementioned goal. The following section describes how the PCCs have operationalised their perception of the new RM; to increase quality of care for their patients through a number of multidimensional initiatives.

5.1 Types of innovation

In this thesis Greenhalgh et al.'s (2008) definition has been used in order to identify innovation, described as *"a novel set of behaviours, routines, and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness, or users' experience that are implemented by planned and coordinated actions"*. Most of the innovations we have identified are just initiatives and thus not implemented changes (see Figure 4.12 on page 56, why they according to Greenhalgh et al. (2008) are not pure innovations. Since the study was conducted shortly after the new RM was implemented, more initiatives are expected to be realised in the future and hence become real innovations. We have also identified innovations aiming to decrease the patient accessibility, as in the case of closing the drop-in clinic at PCC3. Literature mention that not all innovations undertaken becomes positive developments of the organisations (Jones, 2012), which might be the case here.

All PCCs have started to adapt a new strategy to focus more on patients in greater need of care. Strategic innovation has been identified in the BSC for the Financial Perspective; changed focus

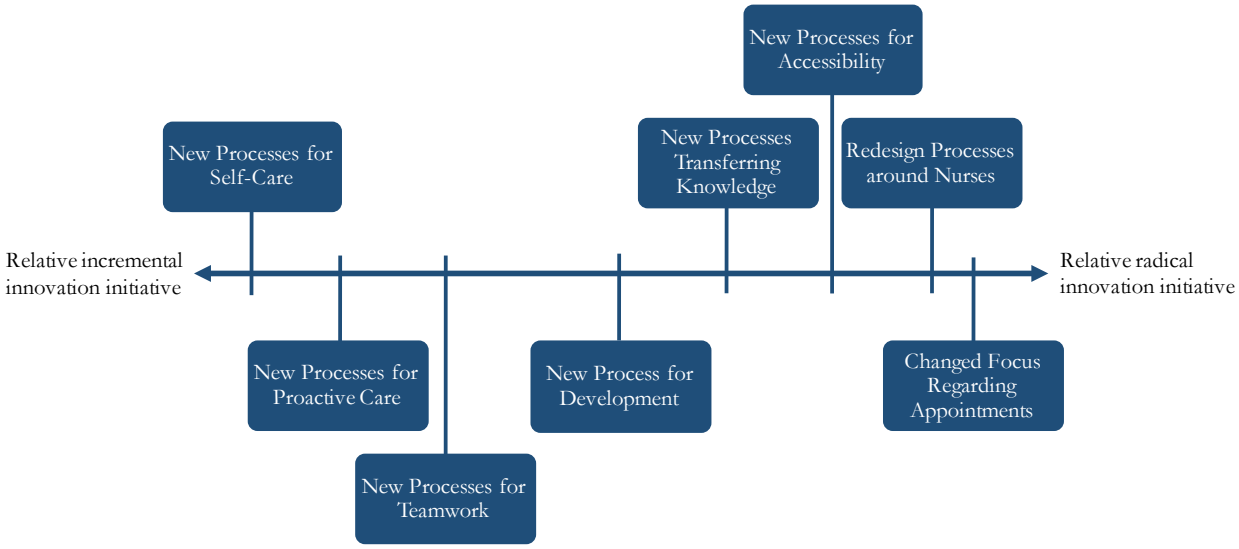
regarding appointments. It was highlighted by all managers that they do no longer need to chase quantities of appointments. The new RM enables a shift in focus to longer appointments with patients in more need of care, rather than several short appointments with healthier patients. This innovation redefines the service offered, from offering several short appointments to longer appointments for patients in greater need. The redefinition of the service offered and for who the business is performed, are requirements for strategic innovations (Markides, 1997).

The new strategy identified has in part been operationalised in terms of numerous process innovations, which have been identified in the perspectives concerning 1. Patients, 2. Internal Business and 3. Learning & Growth. They have been identified as process innovations since they focus on new methods of working, and thereby how the business is performed. (Markides, 1998). Identified process innovations in the patients' perspective are increased accessibility through video appointments, more focus on lifestyle-meetings and increased interaction with self-care educating nurses via telephone. Focusing on the Internal Business Perspective, process innovation has been seen in new processes for increased responsibility to nurses, for example with nurse-led clinics such as the blood pressure and infection clinic. It is also visible in the new processes for teamwork where doctors are expected to function as consultants and nurses will have more patient contact. Lastly for Learning & Growth, process innovation has been identified in processes for transferring knowledge, for example with the implementation of templates for nurses to follow in order to understand how to treat patients better, and with the execution of cross functional working groups encouraged to discuss development ideas for the PCC.

All innovation initiatives identified are incremental since they focus on continuous improvements of the PCCs, aiming to the strategy of improving the quality for more severely ill patients, rather than on completely new services and structures (Baregheh, 2009). However, they range from being pure incremental to slightly more radical. The strategic innovation regarding changed focus on new patient groups is understood to be closer towards being a radical innovation since it is more of a completely

new service, while installing a TV in the waiting room is considered to be relatively incremental innovation since it is a minor change in an already existing way of working. The initiatives are ranked relative to each other based on how radical they are in Figure 5.1 below, note that both implemented and only initiated innovations are presented in the figure.

Figure 5.1 Degree of Incremental Innovations



The figure shows the relative degree of radical innovation of the identified initiatives

5.2 Role of Context

Overall we have identified few differences regarding the affordances to innovate created by the RM as perceived by the different PCCs. The differences identified concerns degree of innovation, number of innovations and one interpretation of the RM. Less radical innovations have been executed within Redesigned Processes around Nurses at the nurse-led and nurse-dense clinics. The clinic with the most innovation initiatives have almost double as many initiatives (11) as the clinic with fewest innovation initiatives (6). Lastly, one PCC decided to close their drop-in reception while another clinic decided to open a drop-in reception.

The difference between responsibility for nurses can be explained by if the clinic is nurse-led and nurse-dense or doctor-led and doctor-dense. Our empirical results indicate that clinics with more nurses

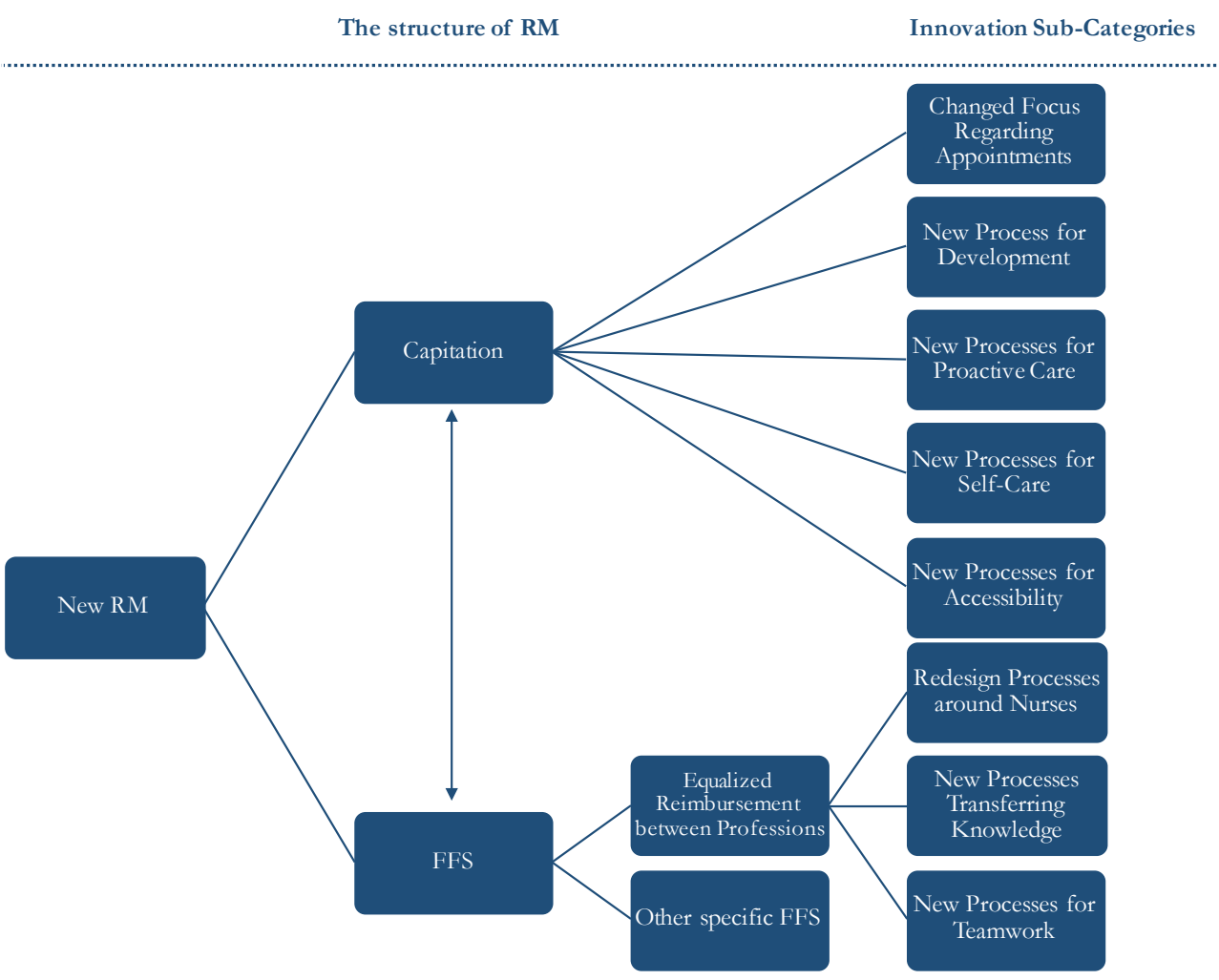
have implemented less radical innovations to increase nurses' responsibility, this is believed to be since the RM has not afforded an equally intense urge to focus on this as nurses already have more responsibility at these PCCs. The other two initiatives cannot be explained based on the data collected. While the context most likely matters, the contextual aspects that we have taken into account did generally not seem to influence the innovation outcomes among the PCCs studied.

We focused our contextual differences on owner structure, largest workforce and managers care profession. Even though the RM had afforded slightly different initiatives, the beginning of a holistic strategy to focus on the patients in more need of care was initiated at all PCCs. Neither if the clinic was led by a nurse or doctor nor if the largest workforce consisted of nurses or doctors, seemed to have had a considerable impact on what innovation initiatives the PCCs had implemented or discussed to implement. The owner structure also seems to have played little value as well in the outcomes of innovation projects. Nevertheless, it is likely that other contextual differences such as management style, willingness to innovate or other undefined preconditions might have played an important role.

5.3 The Role of the RM Design in Affording Innovation Initiatives

Even though the structure of the RM is complex and consist of a long list of components, there are two main components that, according to our empirical results, seem to have been perceived as affording the greatest innovation initiatives at all PCCs. These components are 1. Larger Share of Capitation (fixed reimbursement) and 2. Fee for Services (FFS) The Figure 5.2 below shows a summarised overview of how the PCCs perceive the main components of the RM afford them to initiate innovation. The arrow between Increased Capitation and FFS illustrate how the innovations the RM afford are connected and how the components of the RM creates synergies that impact initiated innovation. This will further be elaborated on in section 5.3.3 Linking the Perspectives.

Figure 5.2 Main Components of RM



The figure above shows the main components of the RM and which initiatives are afforded

5.3.1 Increased Capitation

The increased share of capitation is mentioned by all PCCs as an important aspect of the RM. Since the share of fixed reimbursement almost have doubled compared to the previous RM, the PCCs have a diminished influence on their revenues than before. This affords the PCCs to focus on utilising the resources they have to create value for their patients, rather than chasing quantities of appointments. This change of financial focus is related to Castaneda-Mendez's (1996) dimension within the Financial Perspective of the BSC regarding activity based costing. There is a change of focus from chasing reimbursed activities to rather accept the level of reimbursement and focus on efficiency improvements.

Two PCCs have invested time in new processes for development to promote new ideas and initiatives from the employees, which is aligned with Kaplan and Norton's (1992; 1996) recommendations to improve internal processes. Other initiatives the RM have afforded are initiatives within the Patient Perspective. The new processes regarding accessibility implemented or discussed at the PCCs are mainly technical solutions, such as new systems to make it easier for patients to book appointments, keep in contact with their care givers and conduct appointments more freely with the use of video appointments. These technical initiatives do not only aim to increase value for patients (Kaplan & Norton, 1992; 1996; Castaneda-Mendez, 1996) but also enable PCCs to use their resources efficiently. The PCCs can satisfy the patients' needs without only designing it around a physical appointment. This frees time for healthcare professionals to allocate to patients who actually needs it. Other initiatives the PCCs perceive the capitated element of the RM affords are new processes regarding proactive care and self-care. These initiatives aim to prevent illness and treat the patients before they feel the need to see a doctor, which are aligned with Castaneda-Mendez (1996) dimensions within the Patient Perspective. These initiatives aim to improve the offered service to patients while it also frees time for healthcare professionals.

Several of these initiatives are aligned with the hopes of the initiators, that the RM will be perceived to afford less focus on the number of doctor appointments and increase quality of care to the listed patients. That is, the intention was to stimulate a strategic shift towards increased value for chronically ill patients and innovation within the customer perspective to encourage a shift away from certain revenue maximising *"initiatives"* within the Financial Perspective. However, the before mentioned problem with exploiting the system, in the old RM done through *"unnecessary"* appointments, is not solved by the new RM. One PCC perceived the capitation element of the RM to afford increased home care services due to the relative increase of reimbursement for this service to maximise revenues. Initiators and two PCCs have also highlighted the risk for decreased accessibility due to the increased fixed reimbursement and therefore incentivise to not meet the patients. As of now, one of the PCCs experience direct risk of decreased accessibility, as they have implemented an innovation initiative to close the drop-in reception since it is not financially feasible to keep it. Meanwhile, another PCC have decided to open one. Both actions are described as perceptions the new RM afford. As the affordance theory propose, the perception an object like an RM afford varies among actors and both positive and negative outcomes are predicted and debated (Strong et al., 2014).

5.3.2 Fee for Service

5.3.2.1 Equalised Reimbursement between Professions

The other main RM component mentioned by respondents as affording them new possibilities to change their practice was the relative increased reimbursement for nurses' appointments. Appointments constitute a large part of the PCCs operations and equalised reimbursement between professions thus have a great impact on PCCs. The main innovation initiative afforded by this component of the RM is redesigning the internal processes around nurses. The relative increased reimbursement of nurses' appointments has been interpreted as there is no longer a financial requirement for patients to meet a doctor. Nurses can hence be used to treat patients to a larger extent than before. Since nurses cost less than doctors the PCCs can offer more appointments to the same cost as before while it also frees up

time for doctors. All the same, it is mentioned by the PCCs that the perceived quality of accessibility may decrease due to increased responsibilities for nurses. If the patients expect to see a doctor and not a nurse, they may perceive this innovation as negative.

The other initiatives identified within the Internal Business Perspective and Learning & Growth perspective fills a supportive role to the redesign of the new processes around nurses, while also further increase value of care. New processes for teamwork utilise the specialist competences of both nurses and doctors to increase value for patients. Just like the nurses need to consult doctors in some areas, doctors are consulting nurses regarding other areas, such as when treating patients with diabetes. The initiative regarding New Processes for Transferring Knowledge mainly aims to nurses in the transition process. As nurses are replacing doctors in some services the knowledge and processes must be transferred in order to timely and consistently deliver the services to patients. By giving nurses more responsibilities and by increasing teamwork, the working conditions for both doctors and nurses are said to be improved by all PCCs, which in theory leads to increased motivation and thereby increased performance of the organisation (Kaplan & Norton, 1992; 1996). Giving nurses more responsibility is also aligned with what the initiators hopes the RM will incentives, which also aligns with less focus on doctor appointments. Increased teamwork is moreover mentioned as a specific initiative the PCCs hope the RM will result in. Initiatives to transfer knowledge to nurses is not mentioned as a pre-formulated initiative by the initiators.

5.3.2.2 Other Specific Fees for Services

Introduction of video appointments and increased number of home care appointments is mentioned by almost all PCCs as innovation initiatives the RM has afforded. Video appointments and home care are both pin-pointed reimbursements. The pin-pointed reimbursement for home care is increased and exceeds the reimbursement for regular appointments. It is thus financially advantageous to increase the number of home care appointments with the new RM. The PCCs perceive the RM afford them to increase this service for the listed patients. Having that said, it is also mentioned by PCC3 that

increasing home care is a way for them to utilities their doctors, since home care generates more reimbursement.

Video appointments is either implemented or intended to be implemented shortly at all PCCs. They describe it as a good complement to the traditional care services, to call or meet the patients. The PCCs perceive that the RM afford them to prioritise to implement the equipment for video appointments, due to the pin-pointed reimbursement. Worth highlighting is that calling patients is not reimbursed, which incentivise the PCCs to call the patients using a video link, rather than audio only. Video appointments compared to meeting the patients is more time efficient since there is no time retrieved for the patient from the waiting room or other related activities. Video appointments could therefore be argued to be incentivised, rather than to meet the patients.

5.3.3 Summary of the RM Design and its Effects Compare to Previous Research

Researchers agree that economic influences such as RMs have a great impact on how care is delivered, organised and practiced (Robinson, 1993; Luft, 2009; Latkovic, 2012). In this study we have observed examples of fixed reimbursement in terms of capitation and variable reimbursement in terms of FFS. Regarding capitation, researchers have suggested control of cost as a positive outcome. That proposition aligns with our study, but rather from the perspective of the health care providers; giving them control of their revenues. Negative outcomes from capitation are suggested by previously researchers to be lower productivity, lower quality and less overall responsibility for patients. These negative outcomes are not supported by the identified initiatives in this study. Capitation in this study has rather resulted in increased quality for patients in great need of care and an increased focus on utilising internal resources.

FFS is suggested to generate high productivity, which also is evident in this study for example with the video appointments initiated at all PCCs. After the introduction of new RM an increased equalisation between healthcare professionals have been observed among doctors and nurses due to the equalised

reimbursement between professionals, which further can improve the productivity as resources can be utilised more efficiently. In combination with capitation, this RM has not led to inferior cost control or any sign of lower efficiency as previous literature have suggested regarding FFS. Even though the RM was value-based there are no components in the RM referring reimbursement based on outcome or relative input. Though, an interesting observation is that the anticipated outcome of a value-based RM is increased focus on quality for patient, which has been identified as an outcome of this RM. The theoretical and empirical outcomes are summarised in figure 5.3 below.

Figure 5.3 Summary of the dimensions of the Reimbursement model

	Fixed		**Variable**		
	Fixed budget	**Capitation**	**Fee for service**	**Pay per performance**	**Value based**
Description:	Reimbursement based on predetermined budget (fixed prospective reimbursement)	Reimbursement based on the population (number of people) the Caregiver is responsible for. Can be complemented with other socio-demographical factors such as ACG and CNI (fixed prospective reimbursement).	Reimbursement based on completed activities (retrospective, variable reimbursement).	Reimbursement based on achieved results. Are often used as a bonus in combination with other reimbursement structure	Reimbursement based on achieved outcomes in relative to the input or cost.
Theoretical positive outcome:	- Control of costs	- Control of costs	- High production	- Ability to ward unwanted effects from base model	- Patient focus, economic and professional goals are aligned.
Theoretical negative outcome:	- Low productivity - Passing of Patients to other health Care providers - Quality	- Low productivity - Passing of Patients to other health Care providers - Quality	- Poor cost control - Supplier induced demand - Low efficiency	- Patient selection - Conflicting goals outside the system - Manipulation of coding	- Manipulation of coding
Empirical outcome from a PCC perspective:	N/A	- Control of revenues - Less focus on number of appointments - Increased utilisation of resources - Increased quality - Proactive care - Self-care - Increased accessibility	- Increased utilisation of health care professionals - Increased teamwork between health care professionals - Increased focus on specific activities	N/A	N/A

5.3.4 Linking the Balanced Scorecard Perspectives

The purpose of a BSC from the viewpoint of Kaplan and Norton (1992; 1996) is to translate strategy into linked multi-dimensional objectives and performance measurements, to act on the strategy. It can also be used to explain the connection between the perspectives on an overall level of the organisation. There are a lot of discussion by both initiators and the PCCs about increased quality for chronically ill patients, but relatively few concrete suggestions are formulated; aiming to improve the aforementioned quality. None of the initiators can in detail formulate the causal relationship of how the new RM will increase value for patients. Decision makers of the new RM have been honest with not thinking about the causal relationships of the RM and leave it to the PCCs to interpret and define. It is mentioned at the PCCs that managers are the source of most innovation initiatives while doctors and nurses are acting on those decisions. How is it then that the PCCs have focused on these types of initiatives? Although not all perspectives are explicitly formulated based on each other, we have identified how the different perspectives are linked together.

Based on the beginning of a strategic shift observed at all PCCs, to increase value for chronically ill patients, the PCCs have identified several initiatives to operationalise that strategy. The increased share of fixed reimbursement has limited the PCCs to not increase costs while increasing value for patients. It is perceived that the RM afford PCCs to focus less on number of appointments and thereby achieve increased value for patients through efficiency improvements. The overall shift in targeted patients has in this study determined the scope of how the strategy will be achieved.

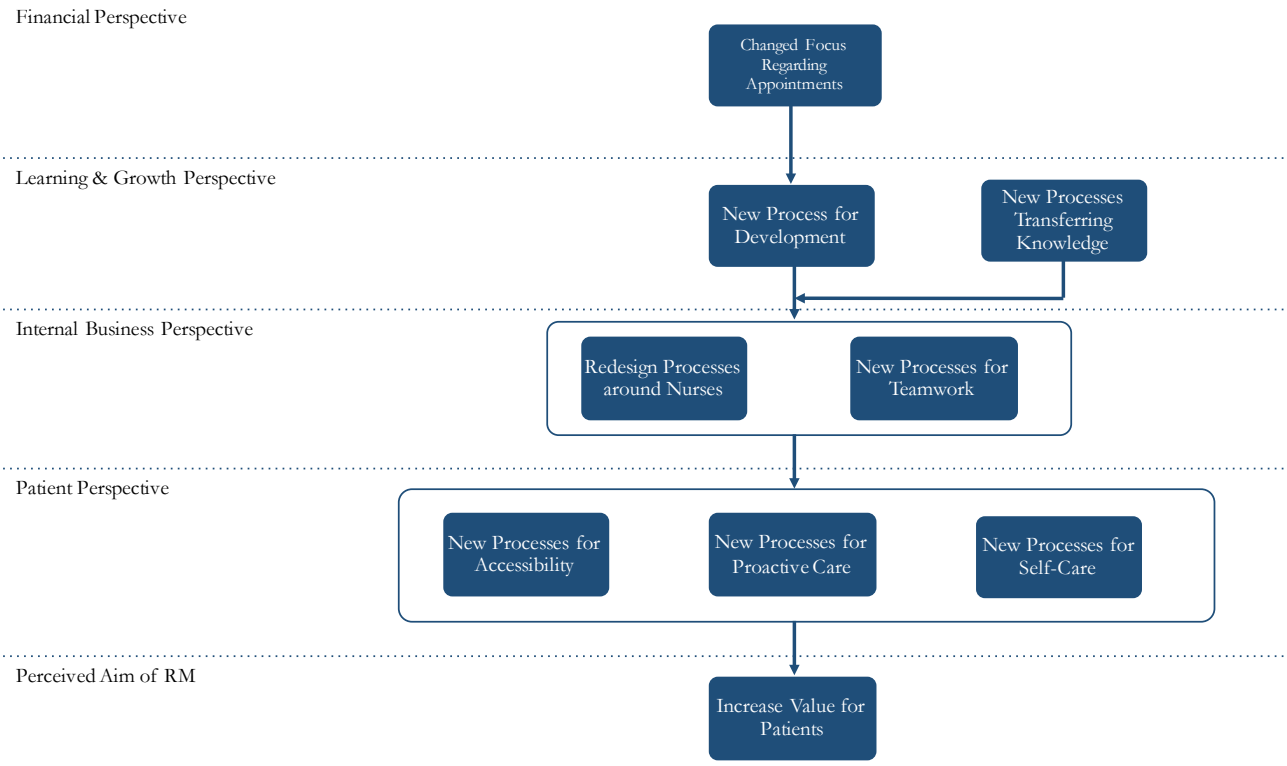
Two of the PCCs have taken initiatives to invite its employees to identify suitable innovation initiatives based on the new strategy. Though, even at these PCCs, initiatives to involve the personnel in a process of development is only mentioned in the passing, and not as an important step to leverage innovation initiatives. The initiatives within the Learning & Growth perspective have not been clearly linked to the new strategy, but rather occur in parallel. The purpose of the New Process for Development initiative has however been to involve employees of the PCCs to think about the operations, and how it can be

improved to increase delivered value for more complex patients. This part of the Learning & Growth Perspective has the potential to leverage innovation initiatives, utilising the new RM in the best way to increase value for patients, even though it has not been a coherent focus by the PCCs. New Processes for Transferring Knowledge fill the purpose of support function to enable initiatives in the Internal Business Perspective.

It is within the Internal Business Perspective the efficiency initiatives have taken place, of which its purpose is to both directly and indirectly increase value for patients. The indirect approach to create value is to use internal resources more efficiently. Ergo, redesigning the processes around nurses the PCCs are utilising nurses as care givers more efficiently and frees time for doctors, which enables them to dedicate more time to the more severely ill patients who need it. The more direct approach to increase value for patients is the initiatives aiming to increase the level of teamwork between healthcare professionals. This initiative fulfils both the purpose to improve value for patients, while it also fulfils an important supporting role in the transition process of giving nurses more responsibilities.

The previous initiatives have directly and indirectly enabled and affected the initiatives to offer value to chronically ill patients. The connections of the different perspectives are summarised in Figure 5.3 below. The initiatives taken by the PCCs clearly shows that the perception of the RM trigger innovation initiatives. The PCCs have both consciously and unconsciously used parts of the BSCs perspectives to operationalise this strategy into initiatives enabling the PCCs to increase value for patients.

Figure 5.4 Linking the Perspectives



The Figure shows how the different perspectives are linked to each other

5.3.5 Value-based Healthcare Assessment

One aim when designing the new RM was to make it more value-based and thereby increase the quality in patient care. However, as we assessed our empirical findings, our analysis implies that how the new RM is being afforded and implemented is not completely aligned with the value-based intention or the theory of what VBHC is. The goal of VBHC is to compete on value, providing the best healthcare possible to the lowest cost possible (Porter, 2008). Through our empirical results it becomes evident that only managers mention financial perspectives, and none of them refer to innovation initiatives aiming at directly lowering costs. Though, increased value for elderly, chronically ill and multi-sick patients are mentioned, why it becomes clear that more focus have been put on value than on costs. Therefore, an initial analysis conclude that the fundamental concept of full VBHC-thinking does not permeate the PCCs yet. Porter (2007) presents six elements that have to be fulfilled in order to display

full VBHC. However, when our interviews were conducted, only three out of the six elements were fulfilled or even mentioned by the PCCs, see figure 5.4 below.

Figure 5.5 Critera and accomplishments of VBHC

Criteria	Accomplishments
Organise into integrated practice units	Nurses and doctors work in consultancy like teams, not cross functional
Measure outcomes and costs of every patient	Not accomplished
Move to bundled payments for care cycles	Partly accomplished
Integrate care delivery across separate facilities	Not accomplished
Expand excellent service across geography	Not accomplished
Build and enable information technology platforms	Started through ex. e-booking and digital forms

An important cornerstone in VBHC is decentralised power (Örtenblad, 2016). In our study nurses have gained more responsibility at all PCCs by leading clinics and assessing the acuteness of patients before booking appointments, and doctors functioned more as consultants for severe patients. Thereby the initiatives taken by the PCCs can be seen as aligning with VBHC. Though, measuring cost is, as previously mentioned, not a focus area by the PCCs. Focusing on bundled payments for care cycles, it is is partly accomplished due to the larger share of capitation. Integrated care delivery across facilities and geography was mentioned by initiators but not by the PCCs, why the intentions by initiators might have been more value based than how it was afforded and implemented by the PCCs. The new RM has encouraged the PCCs to implement new technology such as video appointments, digital forms and e-booking, which aligns with the criteria of VBHC to build and enable information and technology platforms. Our analysis thereby conclude that the new RM has partly been afforded and implemented inspired by VBHC but the PCCs are missing essential aspects to fully be considered as a value-based RM or even VBHC.

6. Discussion & Conclusion

In this section we present our Main Findings, Theoretical Implications and Practical Implications. Hereafter we present the Limitations of Contributions and Suggestions of Further Research.

6.1 Main Findings

The aim of this thesis was to contribute to the research gap regarding what types of innovation is afforded by a new RM by answering the research question:

"How does a new reimbursement model with the political intention of improving the quality and efficiency of healthcare afford primary care practitioners to pursue different innovations?"

Our empirical findings show that the RM afforded several innovation initiatives, culminating in incremental process innovations. We observed a shift in the overarching strategic goal of the PCCs as to improve care for patients, focus more on elderly chronically ill, and multi-sick patients, why most of the innovation initiatives are reflecting this new strategy. In particular, the PCCs responded to the increased capitation and equalised reimbursement between professions, why incentives concerning longer appointments, accessibility, and redesigned processes around nurses gained most attention. Even though different innovation initiatives were identified at the PCCs, few differences concerning how they interpreted the RM was visible. While context most likely matters, the contextual differences we took into consideration seemed to not influence the innovation initiatives nor the degree of innovations particularly, at least in a study of this size with PCCs in the same geographical area.

These aforementioned findings add to the literature, which has previously paid scarce attention to the nuances of innovations afforded by RMs. While these empirical results are tied to the context, the tentative framework provided can be used to study the link between RMs, innovation initiatives and implementations in other settings. These findings can advance knowledge about RMs and innovation, and what design features that may shape this relationship.

6.2 Theoretical Implications

6.2.1 Innovation

In this thesis we complement existing studies on the link of how RMs can afford innovation initiatives, an area that has received little theoretical and empirical attention (Duggan, 2000; Frolich et al., 2007; Lindgren, 2014). Our research support previous literature stating that the structure of the RM can incentivise increased innovation initiatives (Frolich et al., 2007) such as innovations concerning how the care is delivered and structured to increase efficiency and quality, and affect the processes (Duggan, 2000; Lindgren, 2014). This has been identified in for example the initiative to start nurse-led clinics, longer appointments and new processes for prescription renewals.

We have mainly identified levels of incremental process innovations, aiming to improve the quality for patients in greater need of care. Strategic innovation takes longer time and is harder to implement (Markides, 1997), which might be one reason to the few projects identified. Furthermore, the strategy to focus on more severely ill patients as well as the strategic innovation to focus on longer appointments are the major characteristics of all change initiatives. Strategic innovation changes the business plenty and we did therefore expect to see less strategic innovations than process innovations, which also was observed. Moreover, some PCCs mentioned uncertainties concerning the longevity of the new RM, which might create a reluctance to innovate the organisation too much. This is also supported by literature, stating that the high fail rate in healthcare is due to uncertainty and high perceived risk (Jacobs, 2015). In order to create true innovation height and more ventured innovation initiatives, it is thus essential that initiators communicate the longevity of the RM.

6.2.2 Structure of RM

We are contributing to previous research on structure of RMs, especially for capitation, since our findings both support and contradict previous studies. Capitation is debated to both incentivise increased and decreased quality, and focus on cost containment, but also possible avoidance or passing on of complex patients and unfair reimbursement depending on capitation base (Barnum et al., 1995;

Gosden et al., 2001; Deber et al., 2008; Jacobsson & Lindvall, 2009). We support the research stating that capitation incentivise increased quality for patients, however, this also leads to a contradiction since the PCCs experience an increased focus on more severely ill patients and a possible decreased focus on healthier patients. Hence no expected passing on or avoiding complex patients in the new RM but rather the opposite. This might be because the capitation in this RM is based on CNI and ACG, structured so it ensures more reimbursement for more severely ill patients, which limits the incentives to focus on healthier patients. Through delivering an increased quality and value for more severely ill patients, the probability of them staying listed at the PCC increases, ensuring that the reimbursement for the PCC will stay high. Thereby the focus on more severely ill patients is afforded by the RM through capitation based on ACG and CNI while focusing on healthier patients are perceived as less encouraged.

Riksrevisionen (2014) did an investigation stating that the previous RM led to PCCs assembling in areas with good socio-economy, and closed down in areas where the need of care was greater in order to maximise the reimbursement. According to our findings the new RM makes the PCCs more keen on attending to those in greater need of care, why this structure can be favourable for incentivising PCCs to follow the principles of care in Sweden: *"to provide equal care, focusing on those in greatest need of it and hence diminish the problem with PCCs closing down in areas in great need of care"* and thereby reducing the migration of PCCs to healthier areas.

Based on the changes in FFS, the new RM also afford the PCCs to focus on more responsibility for nurses, video appointments and home care. Previous research state that FFS can incentivise high accessibility but also increased healthcare expenditures and risk of over-treating (Barnum et al., 1995; Gosden et al., 2001; Morris et al., 2012). Through our empirical findings we can both support and dismiss this. As our findings indicate the intended outcome of increased accessibility through video appointments, home care and increased responsibility for nurses via nurse-led clinics and increased telephone services, we support previous research. Additionally, the increased use of nurses does not

necessarily lead to increased healthcare expenditures. Allowing nurses to assess less complex patients can be viewed as a more efficient way of using resources since they generally have a lower salary. While it also enables doctors to focus on more complex patients. This allows better working conditions, better use of nurses as a recourse and a possible increase of perceived quality. Albeit, the perceived quality is highly subjective, if the patient expects meeting a doctor and consider meeting a nurse as less favourable, the perceived quality will decrease for both severely ill patients and healthier patients. If the patients on the other hand consider that meeting a nurse and a doctor as equally good, the perceived quality will increase since the increased responsibility for nurses will, according to our findings, lead to increased accessibility, previewed as one step in delivering better quality. Nurses were also said to have an increased responsibility for assessing if patients are in need of care at all, which could result in less *"unnecessary"* appointments, hence over-treating. Having that said, this could also lead to decreased accessibility for less ill patients in contradiction to previous research (Deber et al., 2008; Morris et al., 2012; Lindgren, 2014).

The use of video appointments increases the accessibility as it enables patients unable to visit the care centres to still attend their appointments. This makes it possible for patients to for example go abroad but still attend a follow-up session with their doctor. This service is not thought to increase the healthcare expenditures remarkably since the reimbursement for it is the same as for a normal doctor appointment, why no specific incentives to over-use the service is highlighted.

The implementation of home care aligns with previous research since it increases accessibility for this patient group, but also increase health-care expenditures. One PCC mention the implementation of increased home care services initiated as a means to increase the reimbursement, hence the health-care expenditures. At the same time, the need of home care is growing as the number of elderly and often multi-sick patients that decide or are forced to stay at home instead of moving to a nursing home increase (Socialstyrelsen, 2015). Wherefore, despite increased healthcare expenditures, the indications

of increased home care services due to the new RM, might not be only needed, but more importantly, necessary.

6.2.3 Alignment of the RM and VBHC

This RM was developed to be more value-based than what previous RM used to be in Stockholm. The core of VBHC is to deliver more quality and to decrease costs (Porter, 2006; 2008; 2009; 2010; 2013). An increased focus on quality is seen in for example the opening of new clinics and longer appointments for complex patients, but none of the interviewees mention any direct intention to diminish costs. However, resources are released and used more efficiently as nurses are encouraged to take more responsibility, which lead to increased accessibility of care and decreased work load for doctors, who thereby are able to care for more complex patients. As nurses also are to assess if less ill patients are in need of care and therefore ensure increased avoidance of *"unnecessary"* appointments, it can be seen as a mean to decreasing costs. A VBHC approach further emphasises that care organisations should have flexibility to organise their activities more freely, it is often associated with bundled payment or outcome based payment approaches rather than FFS. Hence, it is questionable to what extent the RM studied is value-based or not. Risk adjusted capitation element is value-based, but FFS elements can be questioned as it orients providers to produce more of a certain thing.

6.2.4 Freedom to Innovate

One of the main goals with the new RM was to increase the freedom and ability to innovate. According to our study, none of the PCCs mentioned this goal, why it can be questioned if the new RM has resulted in increased freedom to innovate or not, and if it is even requested among the PCCs. Still, two PCCs have initiated working groups with the aim to focus on new developments and innovation initiatives for the organisation, why this can be an argument for partly perceived increased innovation height and capacity. Some interviewees mentioned that they neither had the time nor the knowledge of how to innovate their organisation. The innovation initiatives might perhaps rather be a reaction to the compensation than a sign of actual increased innovation capability, evident in for example the fact that none of the PCCs have thought of unique or radical ways of satisfying new

patient groups. Rather have they in relatively similar ways *"complied with"* the perceived intention of the initiators, to increase quality for chronically ill and multi sick patients. Further, the increased use of services that are more reimbursed by the new RM, for instance pin-pointed reimbursement for video appointments which is to be implemented by all PCCs, can be understood as a response to what is expected from the initiators/purchasers, rather than an innovation based on the PCCs own unique capabilities and opportunities in the environment. The reality is probably not so simple that it is either one or the other way. Furthermore, Jacobs (2015) state that 30-90% of the innovation initiatives in healthcare fail, wherefore it is important to remember that we have mostly identified initiatives to innovate and very young innovation projects. Some of the initiatives mentioned might fail and some might never even be implemented, further emphasising the importance of internal learning and external support.

A relevant question to why few radical and strategic innovation initiatives have been identified is hence whether this is due to the structure of the RM implemented or if it is typical for the slow moving industry healthcare represent. Many researchers argue that the majority of RMs hinder innovation initiatives due to the structure (Lindgren, 2014; Vinnova, 2016). According to Lindgren (2014), there are two ways RMs can influence the existence and degree of innovation projects in healthcare:

1. Incentives
2. Structural limits

Incentives can be both hindering and enforcing for innovation projects while structural limits are mostly hindering. For this project the aim of the initiators was to develop a new RM with as few concrete and hindering structural limits as possible such as providing reimbursement for specific actions or treatment methods, and with increased incentives for innovation projects through for example diminished hierarchies. The aim was to develop a more pure and unadorned RM allowing the care givers to think more freely and develop innovation initiatives outside the box. However, as we have

identified in this thesis, the innovation initiatives observed are responses to the incentives given in the RM and therefore not anything new or outside the box despite the intended fewer structural limits.

Some researchers argue that the amount of innovation initiatives outside the box will only increase if the RMs are based on outcome, meaning that the PCCs would be reimbursed based on patient health, satisfaction or other pre-defined parameters. The care givers would thereby take full responsibility for the value they provide, which is only achieved if they have full economic responsibility, hence if they are reimbursed based on for example the value provided to patients. This is a corner stone of VBHC and value-based reimbursement. However despite the stated value-based inspired structure of this RM, reimbursement is not based on value outcome, which might be a reason to why few, if any, innovation initiatives are not directly linked to the incentives provided by the RM itself.

It is thereby debatable if the new RM led to any innovations appart from what was incentivised by the RM itself. If not, this RM function just as any other RM, incentivising innovations within limits specified by the structure of the RM itself. However, the cross-functional working groups can be seen as an opportunity for innovations outside the structural limits of the RM, though we have not identified any specific innovation ideas that could be a sign of this. Therefore, despite that the innovation initiatives identified truly are innovation initiatives by definition, it is highly questionable if this RM encourage and allow for more innovations outside the structural incentives provided by the RM than any other RM have done and would do. Nevertheless it is essential to highlight that the new RM was recently implemented when the data collection for this thesis was conducted, why more convincing results in the favour of VBHC might emerge as the PCCs are given more time to adapt.

6.3 Practical Implications

6.3.1 Initiators

Purchasers of healthcare have great influence on its design through the structure of RMs. Consequently, it is of great importance that they understand their impact and how they can support the PCCs in situations of change. It is also vital that they understand that different preconditions, such as work-force structure, will affect how well and quick the PCCs can adapt to changes in RMs, why it is important to not change the RM too often in order to allow the PCCs to adapt to it. It is also of essence that they keep in mind that in our case, many of the innovation initiatives can be understood as a reaction to the RM rather than an expression of an increased flexibility and innovative height, as they design and implement compensation. This particularly regards the FFS elements of the model, to pay more for certain services is perceived as a guideline, but capitation is not. Hence, given that purchasers want to encourage PCCs to become more flexible, they should increase the share of capitation and minimise the use of targeted elements, such as FFS. At least, they should be aware that they will get more of what they pay for, which means that if the reimbursement for a certain activity are increased, that activity is likely to increase. The purchasers thus need to be clear about what they want; increased innovation initiatives or more of certain services? FFS in some *"new"* services may be good in a transition period, or if a specific service needs increased focus due to for example societal changes, such as home care.

If a RM is mainly perceived as guidelines on what to do, rather than freedom to innovate, then purchasers should investigate the possibilities to reimburse outcome rather than activities, if innovation is their intended outcome. Bundled and/or outcome based reimbursement are more complex since measurements are complex, but worth looking into. We purpose the share of listed patients on sick leave as a measurement for outcome related reimbursement to incentivise the PCCs to help patients to get back to work, which would be of great benefit both for the patient and the society in general. Other measurements could be related to chronically ill and multi-sick patients' health and perceived

satisfaction. An outcome based RM could also deal with the problem that some healthcare providers are taking advantage of the RM to maximise their reimbursement (Järnhult, 2013; Delbanco, 2014).

Furthermore, we have identified the crucial need of education, inspiration and support of managers and personnel as a new RM is implemented, a responsibility that should be shouldered by the initiators. This could also ensure that the RM is afforded as innovation freedom rather than just as reactive reactions to pre-stated intentions. It would be valuable for all healthcare professionals to afford RM in terms of how to utilize RM to accomplish excellent care, rather than maximising billable activities. Therefore, it would be a good idea to incorporate education on innovation in healthcare programs as a tool to improve care.

All these strategies require decision makers and purchasers of healthcare to think about causal chain of outcomes the RM aims to achieve. The framework presented in this thesis could be used by initiators to start thinking about the causal chain of outcomes of a new RM by elaborating on how the RM are most likely to be afforded and operationalised from the perspectives of a BSC. Analysing the causal chain using this framework gives the initiators a foundation to support the PCCs to leverage innovation when implementing a new RM. In this case it could be to encourage the PCCs to invest resources to promote innovation such as the initiative regarding new processes for development. Analysing the causal chain of outcomes from our framework also enables them to redesign the RM and adapt it to support its own objectives before it is implemented to achieve a RM that afford the PCCs to operationalise the intended outcomes.

6.3.2 PCCs

At the PCCs the managers have the main responsibility for the innovation initiatives implemented. It is of great importance that they understand what types of innovation they implement and that it is essential to support the organisations through learning and not just focus on innovations directly related to outcomes. Learning is one of the most important drivers for future innovation. Our analytical framework is thus a valuable tool for understanding how the RM has been interpreted and implemented. The BSC allows the PCCs strategic feedback through understanding within which areas they are focusing their innovation initiatives. For example, the BSC allows us to evaluate the alignment and performance in different perspectives and how they affect each other, why we can identify that the managers should adjust their strategy to put more focus on learning and growth within the organisations in order to allow and ensure for future innovation developments. Managers can also use our framework to assess how to ensure that no area is overlooked and that the initiatives support and reinforce rather than contradict each other.

The framework can also function as a tool to leverage the innovation capacity since it clarifies within what areas resources are needed. In addition, the PCCs should focus on exchanging experiences with other PCCs, to learn and inspire from each other and thereby further leverage their innovation capacity.

6.4 Limitations of Contributions

In an explorative study as this, the approach is descriptive in its nature and the findings may serve as a basis for generalisation but require statistical significance to confirm the generalisability. Whether this RM affects the PCCs in terms of quality and efficiency will be quantitatively investigated later this year by KI and will serve as a basis for the generalisation of the outcome of this RM.

The study objects are limited to a pilot of four PCCs in the same geographical area, why the identified initiatives might be local and not applicable in other areas. However, since the participating PCCs have different characteristics in terms of owner structure, structure of work force and care levels, they should be well suited to predict innovation initiatives of the new RM if it is to be implemented in the whole County of Stockholm.

The PCCs and therewith the managers are randomly selected, but the other interviewees at the PCCs are chosen by the managers. As a result, there is a risk of a biased sample. Managers may have chosen the most positive employees toward the RM to participate in the interviews. This risk was countered by as often as possible conducting interviews individually and encourage the participants to freely speak their mind. With that said, we tried to capture a nuanced picture of both negative and positive aspects.

The participating PCCs in the pilot have gotten more information and support regarding innovation possibilities than if the RM had been broadly implemented in entire Stockholm County. This aspect may have influenced the attention toward innovation and thereby increased the number of innovation initiatives than if the RM had been broadly implemented. Furthermore, the interviewees might have raised innovation initiatives that were to be implemented or were thought of before the new RM was initiated, rather than innovations connected to the new RM. This might have happened in order to be perceived as more successful or because of difficulties in differentiating what projects belonged to the old RM and what projects belongs to the new RM.

6.5 Suggestions of Further Research

The exploitative nature of this thesis opens up for several interesting areas of further research. First it would be interesting to conduct a quantitative study to assess whether our findings about the types of innovations initiated and implemented, are generalisable and therefore applicable for the majority of PCCs in Stockholm County in particular, but also for Sweden and other countries in general. Building on this, broadening the study to include and evaluate reactions and implementations from more PCCs with a broader geographical span and predefined possibilities, would further ensure the generalisability of the study. The material from a broader study like this would be valuable for managers and personnel at the PCCs as inspiration for further developments of the organisations. Building on this a possible future study is to evaluate the innovation initiatives and the degree thereof for PCCs implementing a new RM without the existing support in this project in order to understand the importance of support as a new RM is implemented. Since our findings did not contribute greatly to the research on role of context, we also want to highlight the interest in conducting further research in this area. Furthermore, it would be interesting to investigate what kinds of design combinations of a RM that may work and what they might incentivise, pure capitation or capitation with outcome elements for example. Lastly we suggest a study on how purchasers and initiators can support the PCCs to leverage innovation through the design and implementation of new RMs.

7. References

Adams, R. et al., (2006) "Innovation Management Measurement: A Review", *International Journal of Management Reviews*, 8(1)

Andersen, R. M., (1995) "Revisiting the Behavioural Model and Access to Medical Care: Does It Matter?" *Journal of Health and Social Behaviour,* 36(1)

Baregheh, A., (2009) "Towards a Multidisciplinary Definition of Innovation", *Management Decision*, 47(8)

Barnett, H. G., (1953) *"Innovation: The Basis of Cultural Change"*, New York: McGraw-Hill Book Company, Ed(1)

Barnum, H., et al. (1995) "Incentives and provider payment methods." *The International Journal of Health Planning and Management*, 10(1)

Bazeley, P., (2013) *"Qualitative Data Analysis: Practical Strategies"*, London: SAGE Publications, Ed(1)

Bell, J., (2006). *"Introduktion till forskningsmetodik"*, s.l.:Studentlitteratur Ed(4)

Bitton, A. et al., (2010) "A Nationwide Survey of Patient Centered Medical Home Demonstration Projects", *J Gen Intern Med*, 25(6)

Blanck, A., (2014-01-17) "Sjukvården Hotar bli Nästa Krishärd i Svensk Välfärd", DN Debatt, http://www.dn.se/debatt/sjukvarden-hotar-bli-nasta-krishard-i-svensk-valfard/ (Reviewed 2016-04-13)

Braun, V. & Clarke, V., (2006). Using thematic analysis in psychology. Qualitative *Research in Psychology*. Qualitative Research in Psychology, 3(2)

Bryman, A. and Bell, E., (2011) *"Business Research Methods"*, Oxford: Oxford University Press, Ed(3)

Campbell, S. et al., (2006) "Financial Incentives to Improve the Quality of Primary Care in the UK: Predicting the Consequences of Change", *Primary Health Care Research and Development*, 7(2006)

Caldwell, D.F. et al., (2008) "Implementing Strategic Change in a Healthcare System: The Importance of Leadership and Change Readiness", *Health Care Management Review*, 33(2)

Calltorp, J. (2009). Ersättningssystem inom hälso- och sjukvård. Stockholm, Sveriges Kommuner and Landsting.

Campbell, S. et al., (2008) "The experience of pay for performance in English family practice: A qualitative study", *Annals of Family Medicine*, 6(3)

Castaneda-Mendez, K. et all., (1998) "The Role and Application of the Balanced Scorecard in Healthcare Quality Management", *Journal of Healthcare Quality*, 20(1)

Castaneda-Mendez, K., (1996) *"Value-Based Cost Management for Healthcare: Linking Costs to Quality and Delivery"*, New York: Productivity Press, Ed(1)

Chock, M., (2013) *"A Review of Value-Based Compensation and its Potential to Impact Health care Spend"*, Minnesota: Medical Industry Leadership Institute, Ed(1)

Christensen, C. et al., (2009) *"The Innovator's Prescription - A Disruptive Solution for Healthcare"*, New York: McGraw-Hill, Ed(1)

Coffey, A. and Atkinson, P., (1996) *"Making Sense of Qualitative Data: Complementary Research Strategies"*, Thousand Oaks: SAGE, Ed(1)

Czarniawska, B. and Joerges, B., (1996) *"'Travel of Ideas' in Translating Organisational Change"*, Berlin: De Gruyter, Ed(1)

Czarniawska, B. and Sevon, G., (1996) *"'Introduction' in Translating Organisational Change"*, Berlin and New York: De Gruyter, Ed(1)

Deber, R. et al., (2008) "Models of Funding and Reimbursement in Healthcare: A Conceptual Framework", *Canadian Public Administration*, 51(3)

Delbanco, S., (2014-07-02) "The Payment Reform Landscape: Bundled Payment", Health Affairs Blog, http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment/ (Reviewed 2015-05-02)

Diefenbach, T., (2009) "New Public Management in Public Sector Organisations: The Dark Side of Managerialistic 'Enlightenment'", *Public Administration*, 87(4)

Duggan, M., (2000) "Hospital Ownership and Public Medical Spending", *Quarterly Journal of Economics*, 115(4)

Dunleavy, P. and Hood, C., (1994) "From Old Public Administration to New Public Management", *Public Money and Management*, 14(I3)

Edmondson, A. and McManus, S., (2007) Methodological fit in management field research. *Academy of Management Review*, 32(4)

Eisenhardt, K., (1989) "Building Theories from Case Study Research", *Academic Management Review*, 14

Elliott, R. and Timulak, L., (2005) *"Descriptive and Interpretive Approaches to Qualitative Research: a Handbook of Research Methods for Clinical and Health Psychology"*, Oxford: Oxford University Press, Ed(1)

Ellis, R., McGuire, T., (1996) "Provider Behaviour under Prospective Reimbursement", *Journal of Health Economics*, 5(1996)

Flick, U., (2009) *"An Introduction to Qualitative Research"*, California: SAGE, Ed(2)

Frolich, A. et al,. (2007) "A Behavioural Model of Clinician Responses to Incentives to Improve Quality", *Health Policy* 80(1)

Gama, N. et al., (2007) "Innovation Scorecard: A Balanced Scorecard for Measuring the Value Added by Innovation", in *Digital Enterprise Technology*, New York: Springer US, Ed(1)

Gibson, J. J., (1977) "The Theory of Affordances", in *Perceiving, Acting, and Knowing*, Hillsdale: Hoboken, Ed(1)

Gilfillan, R.J. et al., (2010) "Value and the Medical Home: Effects of Transformed Primary Care", *Am J Manag Care*, 16(8)

Glenngård, A., (2013) "Productivity and Patient Satisfaction in Primary Care - Conflicting or Compatible Goals?", *Health Policy*, 111(2)

Goh, J.M. et al., (2011) "Evolving Work Routines: Adaptive Routinisation of Information Technology in Health Care", *Institute for Operations Research and the Management Science*, 22(3)

Gosden, T. et al,. (2001). *"Impact of Payment Method on Behaviour of Primary Care Physicians: a Systematic Review."* Journal of Health Services Research & Policy, 6(1)

Greenhalgh, T. et al., (2008) *"Diffusion of Innovations in Health Service Organisations: a Systematic Literature Review"*, Oxford: Blackwell Publishing Ltd, Ed(1)

Grumbach, K. and Grundy, P., (2010) *"The Outcomes of Implementing Patient Centered Medical Home Interventions: a Review of the Evidence from Prospective Evaluation Studies in the United States"*, Washington: Patient-Centered Primary Care Collaborative, Ed(1)

Guest, G., et al., (2006) "How Many Interviews are Enough? An Experiment with Data Saturation and Variability", *Field Methods*, 18(1)

Hamel, G., (1997) "Killer Strategies That Make Shareholders Rich", *Fortune*, 135(12)

Hsieh, H.F. and Shannon, S., (2005) "Three Approaches to Qualitative Content Analysis", *Qualitative Health Research, 15*

Hälso- och Sjukvårdsförvaltningen, (2013-10-08) "Förfrågningsunderlag Enligt LOV Vårdval: Husläkarverksamhet med Basal Hemsjukvård", *SLL*

Hälso- och Sjukvårdsförvaltningen, (2014-01-01) "Förfrågningsunderlag Enligt LOV Vårdval: Husläkarverksamhet med Basal Hemsjukvård", *SLL*

Ingmanson, A. et al., (2016-01-13) "Våra Förslag för en mer Effektiv Sjukvård", Dagens Medicin, http://www.dagensmedicin.se/artiklar/2016/01/13/vara-forslag-for-en-mer-effektiv-sjukvard/ (Reviewed 2016-03-16)

Ivanov, C. and Silvia, A., (2014) "Measuring the Performance of innovation processes: A Balanced Scorecard Perspective", *Procedia-Social and Behavioural Sciences*, 109(2014)

Jacobs, S. et al., (2015) "Determining the Predictors of Innovation Implementation in Healthcare: A Quantitative Analysis of Implementation Effectiveness" *BMC Health Service Research*, 15(2015)

Jacobsen D.I., (2002), *"Vad, Hur och Varför? Om Metodval i Företagsekonomi och Samhällsvetenskapliga Ämnen"*, Studentlitteratur AB, Ed(1)

Jacobsson, F. and Lindvall, S. (2009). Utveckling av ersättningssystem inom hälso- och sjuk- vård. Stockholm, Sveriges Kommuner och Landsting.

Jones, C., (2012) "Positive and Negative Innovations in Software Engineering", *International Journal of Software Science and Computational Intelligence*, 1(2)

Järnhult, B., (2013-03-17) "Etik Kontra New Public Management", Läkartidningen, http://www.lakartidningen.se/Opinion/Debatt/2013/12/Etik-kontra-new-public-management/ (Reviewed 2016-04-14)

Kaplan, R.S. and Norton, D.P., (1992) *"The Balanced Score-card: Measures that Drive Performance",* Harvard: Harvard Business Review Press, Ed(1)

Kaplan, R.S. and Norton, D.P., (1996) *"The Balanced Scorecard: Translating Strategy into Action"*, Harvard: Harvard Business Review Press, Ed(1)

Kaplan, R.S., (1998) "Innovation Action Research: Creating New Management Theory and Practice", *Journal of Management Accounting Research*, 10(1998)

Kaplan, R.S., (2003-01-15) "Managing Innovation", *Harvard Business Review*

Kirkpatrick, I. et al., (2005) *"The New Managerialism and Public Service Professions"*, New York: Palgrave Macmillan, Ed(1)

Krohwinkel, A. et al., (2015) "Ersättningssystem för Innovation i Vård och Omsorg", *VINNOVA Rapport*, 2015(08)

Kvale, S., (1995) "The Social Construction of Validity", *Qualitative inquiry*, 1(1)

Latkovic, T., (2012) "Using Payments to Drive Cost-Reducing Innovations", *Health International,* 12

Lazarus, I. and Fell, D., "Innovation or Stagnation? Crossing the Creativity Gap in Healthcare", *Journal of Healthcare Management*, 56(6)

Leifer, R. et al., (2000) *"Radical Innovation: How Mature Companies Can Outsmart Upstarts"*, Harvard: President and Fellows of Harvard University, Ed(1)

Lillrank, P., (1995) "The Transfer of Management Innovations from Japan", *Organisation Studies*, 16(1995)

Lincoln, Y.S. and Guba, E.G., (1985) *"Naturalistic Inquiry"*, California: SAGE Publications, Ed(1)

Lindgren, P., (2014) *"Ersättning i Sjukvården - Modeller, Effekter, Rekommendationer"*, Stockholm: SNS Förlag, Ed(1)

Lofland, J., (1971) *"Analysing Social Settings: A Guide to Qualitative Observation and Analysis"*, Belmont: Wadsworth, Ed(1)

Loue, S., (2000) *"Research Ethics – Theory and Practice"*, New York: Kluwer Academic, Ed(1)

Luft, H.S., (2009) "Economic Incentives to Promote Innovation in Healthcare Delivery", *Clinical Orthopaedics and Related Research* 467(10)

Kim, S.H. and Suh, Y., (2011) "The Relative Efficiency of Service Firms' Innovative Activities", *The Business Review Cambridge*, 18(1)

Markides, C., (1997) "Strategic Innovation", *Sloan Management Review*, 2(1997)

Markides, C., (1998) "Strategic Innovation in Established Companies", *Sloan Management Review*, 39(3)

Markus, M.L. and Silver, M.S., (2008) "A Foundation for the Study of IT Effects: A New Look at De Sanctis and Poole's Concepts of Structural Features and Spirit", *Journal of the Association for Information Systems*, 9(10/11)

Mayring, P., (2000) "Qualitative Content Analysis", *Forum: Qualitative Social Research*, 1(2)

McLaughlin, C.P. et al., (1990) "Total Quality Management in Health care: Making it Work", *Healthcare Management Review*, 15(1)

McLaughlin, C.P. et al., (2002) *"New Public Management: Current Trends and Future Prospects"*, London and New York: Routledge, Ed(1)

Miles, M.B. and Huberman, M., (1994) *"Qualitative Data Analysis: A Sourcebook of New Methods"*, California: SAGE Publication, Ed(1)

Morgan, D.L., (1993) "Qualitative Content Analysis: A Guide to Paths not Taken", *Qualitative Health Research*, 3(1993)

Morris, T. and Lancaster, Z., (2006) "Translating Management Ideas", *Organisation Studies*, 27(2)

Morris, S. et al., (2012) *"Economic Analysis in Healthcare"*, West Sussex: John Wiley & Sons Ltd., Ed(2)

Morse, J.M. and Field, P.A., (1995) *"Qualitative Research Methods for Health Professionals"*, Thousand Oaks: SAGE Publication, Ed(2)

Norman, D., (1999) "Affordance, Conventions and Design", *The Nielsen Norman Group*, 5(1999)

Omachonu, V., (2010) "Innovation in Healthcare Delivery Systems: A Conceptual Framework", *The Innovation Journal: The Public Sector Innovation Journal*, 15(1)

Patton, M.Q., (2002) *"Qualitative Research and Evaluation Methods"*, Thousand Oaks: SAGE Publication, Ed(1)

Peat, J. et al., (2002) *"Health Science Research: A Handbook of Quantitative Methods"*, London: SAGE Publications, Ed(1)

Petterson, A., (2013-05-22) "Vårdcentralerna Kräver Stopp för Ersättningssystem", P4 Jönköping http://sverigesradio.se/sida/artikel.aspx?programid=91&artikel=5541169 (Reviewed 2016-05-02)

Pollitt, C., (1990) *"Managerialism and the Public Services: The Anglo-Saxon Experience"*, Oxford: Basil Blackwell, Ed(1)

Porter, M., (2009) "A Strategy for Health Care Reform - Toward a Value-Based System", *The New England Journal of Medicine*, 361(2)

Porter, M., (2008) "Value Based Health Care Delivery", *Annals of Surgery*, 248(4)

Porter, M., (2010) "What is Value in Health Care", *The New England Journal of Medicine*, 363(26)

Porter, M. et al., (2013) "Redesigning Primary Care: A Strategic Vision to Improve Value by Organising Around Patients' Needs", *Health Affairs*, 32(3)

Porter, M. and Teisberg, E., (2007) "How Physicians Can Change the Future of Health Care", *American Medical Association/Clinicians Corner*, 297(10)

Porter, M. and Teisberg, E., (2006) "Redefining Health Care: Creating Value-Based Competition on Results", *Harvard: Harvard Business Review Press*, Ed(1)

Reid, R.J. et al., (2010) "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers", *Health Affairs*, 29(5)

Riksrevisionen, (2014-11-11) "Mindre Jämlik Primärvård Efter Vårdval och Vårdgaranti", Riksrevisionen, http://www.riksrevisionen.se/sv/om-riksrevisionen/pressrum1/nyheter1/2014/mindre-jamlik-primarvard-efter-vardval-och-vardgaranti-/ (Reviewed 2016-05-06)

Robinson, J.C., (1993) "Payment Mechanisms, Nonprice Incentives, and Organizational Innovation in Healthcare", *Inquiry*

Robinson, C.J., (2001) "Theory and Practice in the Design of Physician Payment Incentives", *Milbank Quarterly* 79(2)

Sahlin-Andersson, K., (1996) "Imitating by Editing Success: The Construction of Organisational Fields' in Translating Organisational Change", in *Translating Organisational Change*, Berlin: De Gruyter, Ed(1)

Saunders, M. et al., (2009) *"Research Methods for Business Students"*, Harlow: Prentice Hall, Ed(5)

Schumpeter, J.A., (1912/1934) "The Theory of Economic Development: An Inquiry into Profits, Capital, Credit, Interest, and the Business Cycle", *Transaction Publisher*, 3(2)

Shortell, S.M., (1999) "The Emergence of Qualitative Methods in Health Services Research", *Health Services Research*, 34(5)

Silverman, D., (2010) *"Doing Qualitative Research: A Practical Handbook"*, London: SAGE Publication, Ed(3)

Socialstyrelsen, (2015-02-27) "Allt Färre Sjuka Äldre Bor på Äldreboende", Socialstyrelsen, https://www.socialstyrelsen.se/nyheter/2015februari/alltfarresjukaaldreborpaaldreboende (Reviewed, 2016-05-02)

Socialstyrelsen, (2013-02-02) "Ekonomiska Analyser" Tillståndet och Utvecklingen inom Hälso- och Sjukvård och Socialtjänst, https://www.socialstyrelsen.se/SiteCollectionDocuments/Ekonomiska-analyser-1.pdf (Reviewed 2016-02-20)

Sofaer, S., (1999) "Qualitative Methods: What Are They and Why Use Them?" *Health Services Research*, 34(5)

Stebbins, R., (2001) "*Exploratory Research in the Social Sciences, Qualitative Research Methods",* London: Sage Publications

Stiernstedt, G. et al., (2016-01-13) "Effektiv Vård", Statens Offentliga Utredningar, http://www.sou.gov.se/wp-content/uploads/2016/01/SOU-2016_2_Hela4.pdf (Reviewed, 2016-02-12)

Stockholms Läns Landsting, (2015-12-01) "Kroninnovation - Värdebaserat Lednings- och Stödsystem för Husläkarverksamheten" *Stockholms Läns Landsting*

Strauss, A.L. and Corbin, J., (1990) *"Basics of Qualitative Research: Grounded Theory Procedures and Techniques"*, Newbury Park: SAGE Publications, Ed(1)

Strong, D.M. et al., (2014) "A Theory of Organization-EHR Affordance Actualization", *Journal of the Association for Information Systems*, 15(2)

Suddaby, R., (2006) "From the Editors: What Grounded Theory Is Not", *Academy of Management Journal*, 49(4)

Sussman, S. et al., (2006) "Translation in the Health Professions Converting Science into Action", *Evaluation and the Health Professions*, 29(1)

Symon, G. and Cassell, C., (2012) *"Qualitative Organisational Research - Core Methods and Current Challenges"*, London: SAGE Publications, Ed(1)

Taylor, W.C., (2006) "Here's an Idea: Let Everyone Have Ideas", *New York Times*

Van Lier, L., (2000) "From input to Affordance: Social-Interactive Learning from an Ecological Perspective", in *Sociocultural Theory and Second Language Learning*, Oxford: Oxford University Press, Ed(1)

Vaismoradi, M. et al.. (2013) "Content Analysis and Thematic Analysis: Implications for Conducting a Qualitative Descriptive Study", *Nursing and Health Sciences*, 15(3)

Vinnova, (2015-12-18) "´Kroninnovation´: Inovationsdrivande Ersättningsmodeller vid Kronisk Sjukdom", VINNOVA, http://www.vinnova.se/sv/Resultat/Projekt/Effekta/2009-02225/Kroninnovation-Inovationsdrivande-ersattningsmodeller-vid-kronisk-sjukdom/ (2016-01-26)

Voelker, K. et al., (2001) "The Balanced Scorecard in Healthcare Organizations: A Performance Measurement and Strategic Planning Methodology", *Hospital Topics*, 79(3)

Vårdgivarguiden, (2016-02-08) "Pilotprojekt Kroninnovation", Stockholms Läns Landsting, http://www.vardgivarguiden.se/AvtalUppdrag/avtalsinformation/huslakarverksamhet/Kroninnovation/ (2016-02-18)

Wilenski, P., (1988) "Social Change as a Source of Competing Values in Public Administration", *Australian Journal of Public Administration*, 47(3)

Winberg, H., (2015-06-01) "Ersättningssystem för Innovation - En Studie av Åtta Projekt som Utvecklar nya Ersättningsmodeller inom Vård och Omsorg", *Stiftelsen Leading Health Care*

Yin, R.K., (2014) *"Case Study Research"*, California: SAGE Publication, Ed(5)

Örtenblad, A. et al., (2016) *"Management Innovations for Healthcare Organisations"*, New York and London: Routledge, Ed(1)

8. Appendix

8.1 Interview Guides

We are Axel Törnvall and Sofia Hagansbo and we study our final semester at Stockholm School of Economics, Master in Management. We are now writing our Master's thesis in collaboration with the research group Clinical Management at Medical Management Centre (MMC) at Karolinska Institutet. They are studying innovative ways to organise and develop healthcare. Responsible at KI are Carl Savage and Pamela Mazzocato.

Clinical Management Group collaborates with Hälso-sjukvårdsförvaltningen (HSF) and the consulting firm IVBAR to conduct and evaluate this pilot project aiming to test a new reimbursement model for primary care. The pilot began in January 2016.

We conduct this interview with managers, medical officers, doctors and nurses at the four selected pilot centres in SCC in order to understand what impact the reimbursement model have on your operations.

The interview will take approximately 60 minutes. The questions are divided into categories, the first section focuses on a few initial questions about yourself and the healthcare centre you work at. This is followed by questions about the reimbursement model, what you think about the changes and what effects it might have had, or that you might be expecting to see.

The questions are open in order for you to freely express your thoughts. Participation is voluntary. You can at any time stop the interview. All data will be treated confidentially and the recordings will be erased after transcription. It is anonymous to participate in the interview since we will not mention your name in any of the documents publicated, only we and the research group at MMC will have access to the interview material. We will also check with you that we have understood you correctly before publication.

We will record the interview in order to make the analysis process more easy going. Is that okay with you?

Turn on the recorder

I have started the recording and I do therefore repeat the question, is it okay that we record this interview?

8.1.1 Primary Care Centre

1. We would like to start with letting you tell us a little about yourself, how long have you been the manager/medical officer/doctor/nurse at this PCC and what is included in your work tasks?
2. What would you say characterise this PCC?
   a. Do this PCC have any particular focus or profile?
3. Can you with your own words describe the new RM? What do you think is the purpose of these changes? Exemplify?
4. How does the new RM affect your work?
   a. Has it affected how you distribute your working hours? (Administration, time with patients, improvement work) In what way? Exemplify!
   b. Has it led to changes in your work tasks? (Reporting, scheduling, monitoring of patients, more flexibility) In what way? Exemplify!
5. Does the new RM affect the work at the PCC as a whole? (Policies, procedures, resources, etc.) In what way? Exemplify!
6. Does the new RM, affect how you collaborate with other healthcare providers? Exemplify!
7. Is there any part of the new RM that you feel have a greater impact than others? (ACG, increased capitation, equalised reimbursement between professions, reimbursement for video appointments, reimbursement for fewer specific actions (KVÅ-koder), no specific goal-oriented reimbursement, increased reimbursement for home care, removal of reimbursement for interpreter)

According to HSF, the aim of the new RM is to *"provide greater freedom for caregivers to design their organisation around their listed patient's needs. The aim of the project is to increase the provided quality for patients while maintaining accessibility"*.

8. How well do you think the design of the RM captures that purpose?
9. How well do you think that the project has been communicated?
    a. How were you introduced to the new RM? What did you think about the introduction? Was it clear? Exemplify!
10. How much do you discuss (between managers/ between colleagues) the new RM?
    a. Have the new RM affected how much you talk about financial goals for the PCC? How? Exemplify?
11. Doe the new RM create incentives and opportunities for you to develop and improve the PCC? Exemplify!
    a. Does the new RM encourage initiatives? How? Within a particular area? Exemplify!
    b. How would you say that ideas and initiatives are received by managers, colleagues and SCC? Exemplify!
    c. How do you involve patients in the development of the PCC?
12. Can you think of any example when the new RM implied new restrictions?

Now we will ask some questions about the perceived or expected effects of the new RM.

13. What (positive or negative) effects have you or are you expecting for:
    a. Patients? (Patient quality and value? Specific patient groups?)
        i. Do you think that the accessibility for patients can be affected in the new RM? (Risks and opportunities)
        ii. How can you ensure good accessibility for patients with the new RM?
    b. Employees (job satisfaction, stress, skills)?
        i. Resources at the PCC?

14. If you were to dream freely, how would you design and implement the RM in the future?
15. How do you perceive the support of HSF?

a. Is it anything in particular that has worked well? What more support would you like?

16. Is there anything else you want to mention or that we forgot to ask?

17. Based on what we have discussed, is there anyone else you think that we should talk to or any documents we should take part in?

Thank you! We will get back to you when we have analysed the interviews. If you have any questions, you can contact Carl Savage (carl.savage@ki.se), Pamela Mazzocato (pamela.mazzocato@ki.se), Sofia Hagansbo (50167@student.hhs.se) and Axel Törnvall (50210@student.hhs.se)

8.1.2 Interview Guide - Initiators

1. We would like to start with letting you tell us a little about yourself. What is included in your work?

2. What role did you have in the design and implementation the new RM?

   a. What role did HSF/SCC/your party have in the design and implementation of the new RM?

3. Can you with your own words describe the new reimbursement model? What do you think the purpose of these changes are? Exemplify?

   a. What were the fundamental ideas or principles behind the new RM?

4. How do you expect that the taken approach will lead to the stated objectives? (causal chain, step by step, logic) Which actors were (especially) active/involved in the design of the new RM?

   a. What role has the politicians, HSF, PCCs, patients, IVBAR, Idérådet and Karolinska Institutet had?

   b. From where do the initiatives come from?

5. Have you been involved in design/development and evaluation of the project?
   a. How is the project supposed to be evaluated?
6. Do you think that the new RM has/will affect the PCCs? In what way? Exemplify? (Policies, procedures, resources, etc.)
7. Do you think the new RM has/will affect how the PCCs collaborate with other healthcare providers? Exemplify!
8. Is there any part of the new RM that you feel have a greater impact than others? (ACG, increased capitation, equalised reimbursement between professions, reimbursement for video appointments, reimbursement for fewer specific actions (KVÅ-koder), no specific goal-oriented reimbursement, increased reimbursement for home care, removal of reimbursement for interpreter)

According to HSF, the aim of the new RM is to *"provide greater freedom for caregivers to design their organisation around their listed patient's needs. The aim of the project is to increase the provided quality for patients while maintaining accessibility"*

9. How well do you think the design of the reimbursement model captures that purpose?
10. How well do you think that the project has been communicated to the PCCs? What could be better? Exemplify? (Only HSF)

11. How does the new RM incentives opportunities for the PCCs to develop and improve their healthcare activities? Within a particular area? Exemplify!
    a. How do you think that the PCCs adapt to the new RM through developing new ideas and initiatives? Exemplify!
    b. Do you think that this approach can be improved? Exemplify!
    c. How do you support the PCCs to develop new ideas and initiatives? Exemplify!
12. Can you think of any example when the new RM implied new restrictions for the PCCs?

Now we will ask some questions about the perceived or expected effects of the new RM.

13. What (positive or negative) effects have you or are you expecting for:
    a. Patients? (Patient quality and value? Specific patient groups?)
        i. Do you think that the accessibility for patients can be affected in the new RM? How? (Risks and opportunities)
        ii. How can the PCCs ensure good accessibility for patients with the new RM?
    b. Employees (job satisfaction, stress, skills)?
    c. Resources at the PCC?

14. If you were to dream freely, how would you design and implement the RM in the future?

15. What have you done to provide support to the PCCs in the process of change due to the new RM?
    a. Can you give examples of specific things that have worked well? What more areas do you think need support?
    b. Has Kroninnovation affected how you work at HSF? (Only HSF)

16. Is there anything else you want to mention or that we forgot to ask?
17. Based on what we have discussed, is there anyone else you think that we should talk to or any documents we should take part in?

Thank you! We will get back to you when we have analysed the interviews. If you have any questions, you can contact Carl Savage (carl.savage@ki.se), Pamela Mazzocato (pamela.mazzocato@ki.se), Sofia Hagansbo (50167@student.hhs.se) and Axel Törnvall (50210@student.hhs.se)

8.2 List of Interview Participants

Interviewee	Organisation	Position	Date	Time
Int_1_HSF	HSF	Project Manager	March 18th 2016	60 min
Int_2_HSF	HSF	Project Initiator	April 14th 2016	31 min
Int_3_SCC	SCC	Party Representative	April 4th 2016	59 min
Int_4_SCC	SCC	Party Representative	April 7th 2016	49 min
Int_5_SCC	SCC	Party Representative	April 1st 2016	68 min
Int_6_M1	PCC1	Manager and Medical Officer	March 7th 2016	54 min
Int_7_D1	PCC1	Doctor	March 7th 2016	38 min
Int_8_N1	PCC1	Nurse	March 7th 2016	61 min
Int_9_N1	PCC1	Nurse	March 7th 2016	37 min
Int_10_M2	PCC2	Doctor and Medical Officer	February 18th 2016	56 min
Int_11_D2	PCC2	Doctor	February 18th 2016	57 min
Int_12_D2	PCC2	Doctor	February 18th 2016	57 min
Int_13_N2	PCC2	Nurse	February 18th 2016	70 min
Int_14_M3	PCC3	Manager	February 25th 2016	79 min
Int_15_D3	PCC3	Doctor	March 10th 2016	56 min
Int_16_D3	PCC3	Doctor	March 10th 2016	56 min
Int_17_N3	PCC3	Nurse	March 10th 2016	56 min
Int_18_M4	PCC4	Manager	March 4th 2016	75 min
Int_19_D4	PCC4	Doctor	March 4th 2016	38 min
Int_20_D4	PCC4	Doctor	March 4th 2016	85 min
Int_21_N4	PCC4	Nurse	March 4th 2016	75 min

8.3 Code Book

Code book

Category	Sub-category	Code	Description
Overall Perception	Quality of care	Chronically ill, elderly and multi-sick patients	Incentives focus on chronically ill, elderly and multi-sick patients
		Listed patients	Greater responsibility for the listed patient's health
	Allocation of resources	More responsibility for nurses	Expected to be able to shoulder more responsibility in care provided
		Less stress	With more equality i responsibility, less stress is expected for both professions
		Longer appointments	Allowing longer appointments
	Freedom to innovate	Increased freedom to innovate	More freedom to focus on innovation ideas for improving care and quality
	Attitude	Positive	Positive attitude toward the new RM
		Right but not enough	Right direction, but some aspects still missing, such as reimbursement for psychology
		Aligned with purpose	The structure of the RM aligns with purpose
	Perceived risks	Decreased accessibility	Decreased incentives for many appointments might lead to decreased accessibility
		Decreased perceived accessibility	Fess ill patients since they are not as prioritised and due to less appointments with doctors and more with nurses
		Capacity	Low capacity to innovate since PCC structure aligns with old RM
		Uncertainty	Lowered innovation incentives due to uncertainty in persistence of RM
Patient Perspective	New Processes for accessibility	New clinic	The opening of an infection clinic
		Telephone/Operating/Booking system	New or increased telephone service,
		Video appointments	For easier cases or when more convenient for patient
		Removal of clinic	Shutting down drop-in clinic
		Extended communication methods	New ways of communicating through sms, digital forms and e-mails
		Home-care	The new RM allows more focus on these patients
	New Processes for proactive care services	Prescription renewal	Better Processes for prescription renewal
		Life-style clinic	More focus on life-style clinic
	Self-care	Telephone education	Nurses informing patients via telephone on self-care
		Patient education	Patient education focusing on self-care
Internal Business Perspective	Redesigned Processes around nurses	Nurses responsible for new/more clinics	Such as infection clinic, blood pressure clinic, diabetes clinic
		Time-scheduling	Open up the schedule for nurses to enable more patient contact
	New Processes for teamwork	Cross professional teams	Improved collaboration between healthcare professions
Learning & Growth Perspective	New Processes for transferring knowledge	Doctors as consultants	Nurses responsible for more patient contact and doctors function as consultant to allow knowledge to transfer from doctors to nurses
		Process development	Doctors encouraged to develop Processes for transferring knowledge
		Instructions and manuals	Doctors wrote manuals and instructions for nurses to follow to assess patient cases better
	New Processes for development	Cross-functional working groups	To ensure discussion and promote innovation ideas
		Study-visits	The personnel have study visits at the different clinics within the PCC
Financial Perspective	Changed focused regarding appointments	Less focus on booking many appointments	Less focused on many short appointments