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The creation of a management fashion – contextualization in practice

A CASE STUDY OF VALUE-BASED HEALTH CARE'S INTRODUCTION AT THE KAROLINSKA UNIVERSITY HOSPITAL, IN STOCKHOLM, SWEDEN

ABSTRACT

This study charts how "Value based health-care delivery", a management idea created by Michael Porter and Elizabeth Teisberg, and promoted by the Boston Consulting Group, has been translated in a Swedish context, up until August 2017. It traces the travel of the concept, from its origins, to its meteoric rise within the Swedish healthcare system, culminating in its operationalization at the Karolinska University Hospital, as the cornerstone of a wide ranging reorganization. In doing so, it provides a rich description of the various actors, agendas, and actions central to its contextualization; providing a perspective on a contemporary societal phenomenon, at the intersection of private, public, and academic sectors, which carries with it potentially far reaching implications for both its users and creators.

The empirics are largely based on primary research, consisting of interviews with the concept's key proponents and consumers, on a top management level, as well as various third parties who were key to its contextualization, or otherwise had significant insight into the process.

To examine the process of institutionalization, as opposed to its outcomes in posterior, this study drafts a theoretical framework. The framework is grounded in the sociology of translation, and (re)introduces the concepts of power and sensemaking – drawing inspiration from Czarniawska's metaphor of emerging institutions as anthills (2009), and Røvik's calls for an instrumental theory of knowledge transfer as translation (2016). In other words, providing a pluralistic and pragmatic take on institutional entrepreneurship.

Thus, the study offers a peek into the inner workings of a large scale change effort, the instrumental capacity of a management idea, and the challenges met when trying to affect the sensemaking apparatus of a highly institutionalized organization. Providing a telling example of how a management idea, turned fashion, can function as a powerful instrument creating sustainable competitive advantage in the business of ideas, among the merchants of meaning. Yet, it was not only useful for its creators, but this is an idea which seemingly became such strong a fashion due to its ability to be utilized by several actors to pursue forceful change, each to their own agenda. In other words, an examination of contextualization in practice, and "what the process of institutionalization looks like" (Ahrne et al., 2007) in its early stages.

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A number of individuals have been of great aid to this study, people who I would like to issue my heartfelt thanks.

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Thus, after five years at the Stockholm School of Economics, a place I have come to call home, one phase ends, and another begins.

Across the street from NKS, Stockholm, August 19, 2017

Oskar Kolmodin

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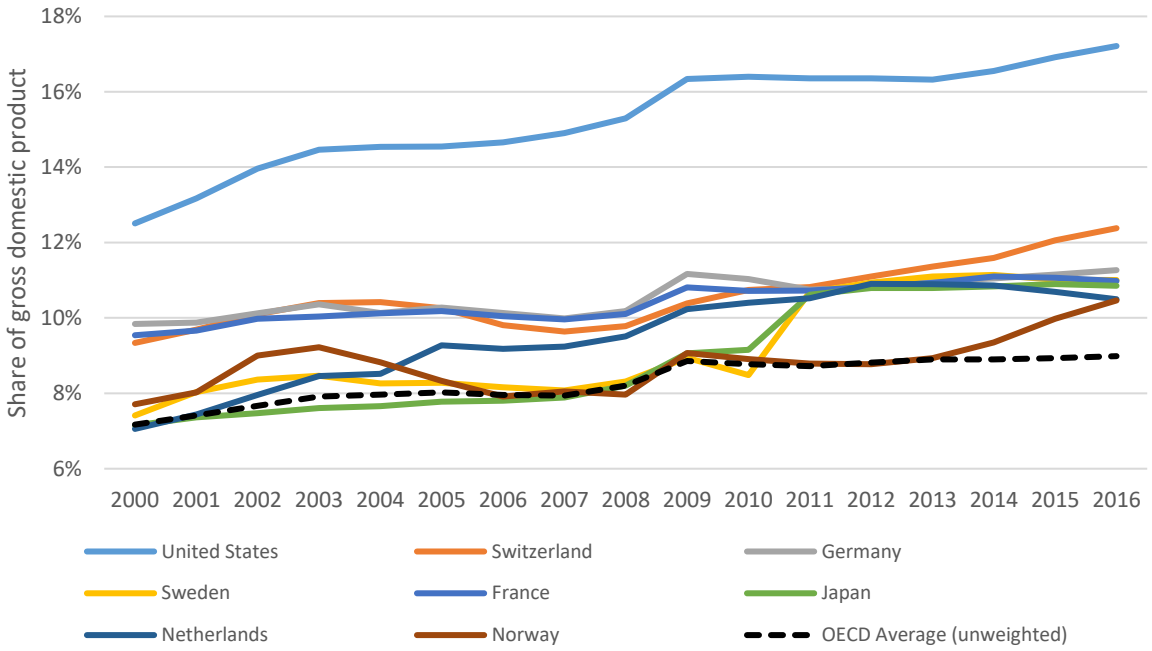
INTRODUCTION

Healthcare expenditures are rising. Whilst the largest spender, by far, on all accounts, is the United States, the phenomenon is global. One country facing this situation is Sweden. In fact, in terms of growth of expenditure, from 2000 to 2016, Sweden has increased its healthcare spending, as a share of GDP, by 49%, compared to the US 38%.

Figure 1. Healthcare expenditure in the OECD – Top 8 spenders, in share of GDP (OECD, 2017)



Healthcare is a hot topic in Sweden, not least within the public sector. In Intellecta's review of 2017's highly influential politician's week[1], healthcare was ranked as one of the most frequent topics across all events.

Within healthcare, no project within Sweden today, and especially within Stockholm, seems as fervently discussed or as hotly contested, with one crisis after another being reported in the press, as the new Karolinska University Hospital (NKS[2]). A project[3], or mega-project if you will, aimed at being ultramodern in neigh every dimension, ultimately governed by the Stockholm County Council (SLL), which was "Skanska's largest project ever" (Skanska, 2017), the county's largest (SLL, 2009), as well as the single largest project thus far within Swedish healthcare (SR, 2010; NKS, 2016). Not only are the construction, run by Skanska; the financing agreement supporting it, run as a form of public

[1] Swedish: Almedalsveckan/Politikerveckan

[2] NKS is the acronym of the new hospital building in Solna, in northern Stockholm, situated just next to the old hospital building, which was still in construction at the time of writing.

[3] The costs of construction and equipment are calculated to reach SEK 22,8 billion, with an additional approximate SEK 38,2 billion operating costs, until 2040, totaling SEK 61 billion (USD 7,32 billion) (NKS, 2015)

private partnership[4], in cooperation with Innisfree, a British investment fund; and the procurement processes, under close scrutiny, but also the healthcare delivery itself.

What is perhaps not as commonly known, is that running simultaneously with constructing, supplying and moving into the new hospital building, is another far-reaching change process, aimed at the (hitherto unseen) wide-scale implementation of something called Value based health care delivery – or "Värdebaserad vård" as it is called in Sweden. A concept, largely promoted by Boston Consulting Group (BCG), a management consultancy. Yet, apart from a couple of reports on Swedish Radio by Per Shapiro, on the "total reorganization" that is occurring and the management idea behind it (Shapiro, 2016a, 2016b), little has been done to provide a holistic perspective on what is happening *within* the hospital, and its new operational model, as they call it (Samsom, Ringman Uggla).

The aim of this paper is thus to shed light on what this widely discussed concept is; how it has risen to prominence within the Swedish health care sector, centered on Karolinska, who are shown to be at the fore; who its main proponents have been; how it has been implemented, if at all; and why. The rise of this idea within the Swedish health care system has subsequently been shown to be part of a much larger playing field, at the intersection of private, public, and academic sectors, with potentially far reaching implications for the both its users and creators.

From a theoretical standpoint, rooted in neo-institutionalism and the sociology of translation, it will thus trace the so called "travel" of the concept, and elucidate the dynamics affecting it, focusing on its contextualization within Sweden, with Karolinska at its focal point; its epicenter. Thus, providing an example of "what the process of institutionalization looks like", as called for by Ahrne, Brunsson and Tamm Hallström (2007), in its early stages, by examining the concept's first test-bed and the chain of events leading up to its introduction. In part, to "distinguish the micro-processes that may explain why some organizational elements are institutionalized and others not", as called for by Seidl, in the same issue. This will be achieved, by building on the metaphor of emerging institutions as anthills by Czarniawska (2009), as well as Røvik's work to provide an instrumental theory of translation (2016), and (re)introducing the concepts of power and sensemaking.

As this is an exploratory pursuit, seeking to contribute to both future research and common understanding, the results section will be largely empiricist in tone; seeking richness and narrative in presentation, with a largely chronologic perspective. The discussion section, on the other hand, concerns itself less with chronology, rather seeking to gain access to deeper structures, in particular within the change process itself, by tracing the logical structure (cf. Kairotic time in e.g. Czarniawska, 2009), akin to that presented in the theoretical framework. Lastly, the concluding remarks will briefly discuss the potential implications.

[4] Swedish: Offentlig-privat samverkan (OPS)

RESEARCH QUESTION

In summary, this paper will seek to **CHART HOW VALUE BASED HEALTH-CARE DELIVERY HAS BEEN TRANSLATED IN A SWEDISH CONTEXT**, by answering the following sub-questions.

1. WHAT IS IT?
2. HOW DID IT TRAVEL?
3. WHO WERE INVOLVED, AND WHAT DID THEY SEEK TO ACCOMPLISH?
4. HOW WAS IT RECEIVED BY THE ORGANIZATIONS INTENDED TO IMPLEMENT IT?
5. WAS IT OPERATIONALIZED, AND IF SO, HOW?
6. HOW DID IT FUNCTION?
7. WHY DID THE MEMBERS OF THE TARGET ORGANIZATION RESPOND IN THE WAY THEY DID?

DELIMITATIONS

As the study traces the travel of the concept, Sahlgrenska University Hospital, and Uppsala University Hospital both had parts to play. That said, the spatial focal point of this study is Karolinska University Hospital, and the network of key stakeholders around it, mostly present within Stockholm county. Additionally, the contextualization of the idea is in focus, with the decontextualization only touched upon in brief.

The emphasis of the study is thus the reorganization and its prelude, but not the procurement or construction processes, which will be covered in an upcoming study of NKS by SCORE[5]. For literature on the management of so called mega-projects, Kerstin Sahlin-Andersson (1989) and Bent Flyvbjerg (2003, 2014), as well as the latter's Oxford handbook (2017) on the matter, are a good start.

The studied perspective is mainly that of the managers, the decision makers, and consultants, as well as some third parties. The latter was drawn upon, coupled with the variety of stakeholders interviewed, and supplementary secondary data, as well as a wealth of media coverage, to reduce the risk of bias, and enable greater triangulation of data.

In terms of time, the study does not particularly investigate the very first steps of the strategy formulation within SLL, as mainly espoused in "Framtidsplanen" ("The Plan for the Future") in 2011[6], leading up to NKS. Furthermore, although some comparisons are made and some history reviewed, the approach is mainly that of an in-depth perspective of the new, rather than the old (e.g. NPM, Lean, DRG, and budget costing). A historic overview of the steering- and operational models employed within Swedish health care is left to other studies.

It should also be noted, that this paper does not seek to evaluate the concept, nor the actors involved in a normative sense.

[5] Stockholm Centre for Organizational Research

[6] The plan consisted of three parts, published consecutively (SLL, 2011, 2013, 2015).

THEORY

As the overarching theoretical subject is knowledge transfer, the travel of ideas, and their contextualization, and to a lesser extent also the ensuing organizational responses – all within the early stages of the process of institutionalization – translation theory was chosen as the theoretical foundation of the discussion presented herein. Thus, the school of thought is neo-institutionalism, and more specifically the Scandinavian school. Notably, the Scandinavian school considers both social and regulatory institutions, as well as "soft laws", such as standards (which elicit conformity by providing legitimacy), and has typically employed case-based qualitative studies.

Within the school, the point of origin is the sociology of translation, as described in Czarniawska and Sevón's editorial (1996). Translation in this sense, is a metaphor to replace diffusion (as espoused by Latour in 1986), emphasizing the linguistic, rather than physical qualities, and the tandem and transformative relationship of both broadcaster and receiver.

BACKGROUND

NEO-INSTITUTIONALISM

The "new" institutional school, had its foundation in the late 70s and early 80s, creating nascent theory seeking to capture the effects of societal norms and values on organizational behavior. The emphasis was on shared meanings, institutional processes and conformity (i.e. isomorphism) in relation to legitimacy, and why organizational behavior is sometimes strikingly irrational, at times even strictly ceremonial in nature (i.e. a form of decoupling).

One of the pioneering works of early institutionalism was that of Meyer & Rowan (1977). Their paper spoke of "the complexity of networks of social organization and exchange" and "the institutional context", wherein, in part, "institutionalized organizations", where there is an ambiguity of effectiveness and causality, are especially subjected to appear 'rational'.

Another key work was that of DiMaggio & Powell (1983), arguing that "networks/fields are thus both antecedents of rationalized myths and vehicles for their transmission" (Greenwood et al., 2008), i.e. a continued emphasis on "institutional context" and "rationalized myths". That said, its key contribution, at least in number of citations, was the three proposed "mechanisms of diffusion" – coercive, normative and mimetic isomorphism.

Scott, Zucker and Tolbert were also part of the defining cast (Greenwood et al., 2008), where the latter two, in part, spoke of "institutionalized practices" and their characteristics, and how organizations are "captives of the institutional environment in which they exist" (Tolbert & Zucker, 1983). In other words, the school broke with the theory of rational choice, by espousing the centrality of a logic of appropriateness, rather than a logic of consequentiality, in governing organizational behavior.

From the early 80s until the early 90s, the first theories were, as Scott (2005) said, "confronted with data". The emphasis was largely on organizational fields, the question of legitimacy and ensuing homogenization as a means of reducing uncertainty and appearing rational. The studies took on a wide range of empirical applications, which can be divided into four sets: processual, cross-category, cross-national and means of transmission (Greenwood et al., 2008), the latter of which this study ties

into. Notably, the studies were also heavily quantitative in their empirics, especially the processual ones (cf. Tolbert & Zucker, 1983, 1996; Greenwood et al., 2008).

All the same, the studies of this era focused heavily on the mimetic process as a driving mechanism for isomorphism (Mizruchi & Fein, 1999). The concept of exogenous shock also saw its birth during this time-period (Fligstein, 1987), later spawning the concept of "institutional entrepreneurs"; emphasizing rational actors and how one can handle steering and strategy in response to the institutional environment.

THE SCANDINAVIAN SCHOOL AND THE SOCIOLOGY OF TRANSLATION

Meanwhile, translation theory (or more specifically, the sociology of translation) was a response to the neo-institutional school, as presented in the late 80s and early 90s, which it decried as overly emphasizing the homogenizing aspects of isomorphism – i.e. as having an overly static view of knowledge transfer and the diffusion of ideas, in part by viewing institutions as largely environmental and monolithic in nature (Czarniawska & Sevón, 1996). The perspective rather highlighted the (mutually) transformative capacity of knowledge transfer, and implied that the process of translation necessarily results in heterogeneity in the contextualization of ideas.

However, translation theory did not exist in a vacuum, but was a subset of Scandinavian institutionalism, as coined in 1996 by Czarniawska & Sevón. Some of the first defining works are those of Jacobsson (1987, 1989), Olsen (March & Olsen, 1989) & Brunsson (1985, 1989), speaking of myths contra reality in steering, decision rationality, "the irrational organization", and forms of "organized hypocricy". Czarniawska & Sevón (1996) argued that the school took a different stance on organizational change compared to other institutional theory, rather akin to that of the pragmatic tradition of Thurman Arnold, where "Change and stability together become an organizational norm, as the logic of appropriateness is seen as complementary to the logic of logic of consequentiality".

Applying this within translation theory, rooted in the work of Latour and actor network theory, Czarniawska & Joerges (1996) viewed organizational action as based upon a "collective apparatus of sense-making" (cf. Weick, 1995), arguing that "change is a result of a blend of intentions, random events and institutional norms". Thus, agency was readmitted into the picture, whilst criticizing what its proponents often voice as an "American" view of largely rational actors, acting independently in a top down manner.

The empirical foundations of the school are seemingly two-fold. First off is the Swedish concept of "Praxis", i.e. non-written rules and procedures, tying into the concept of espoused vs de facto ways of working and decision rationality. Secondly, around the time of its foundation, the NPM wave hit Sweden, which provided plenty of research opportunities within the public sector, which has remained a key empirical focus to this day. Tying into this, the Scandinavian school has largely been built on case based qualitative studies, in contrast to the large macro-level outlooks rooted in quantitative studies employed in many of the defining works in the US. Arguably, this was enabled, or at least aided, by the Swedish openness principle, whereby nearly all documentation and data in the public sector is available to the public. Furthermore, given the far-reaching impact of NPM, it should not come as a surprise that Brunsson spoke of institutional confusion (1994) around the same time that institutional logics were first spoken of across the pond (cf. Friedland & Alford, 1991), whereby the incompatibility of logics are a mechanism for change.

Later developments within the school focused on various forms of "soft" regulations, such as standards (Brunsson & Jacobsson, 1998; Brunsson, Rasche, Seidl, 2012), accreditations (Hedmo, 2004) and rankings (Wedlin, 2006); eliciting compliance by providing legitimacy (Greenwood et al., 2008). Overarchingly, this can be described as various takes on how to organize organizations (Ahrne et al., 2007), which also include partial organization (Ahrne & Brunsson, 2011), metaorganizations (Ahrne & Brunsson, 2008), and the creation and travel of management knowledge and the work of "experts" (Furusten & Werr, 2016).

A key question raised, although left unanswered (Ahrne et al., 2007), is "some organizing over time becomes institutionalized; it is important to know much more about the factors that determine why that is the case and what the process of institutionalization looks like", whereby as emphasized by Seidl, same issue, "many of the dynamics involved in rules becoming institutions will be overlooked if we begin with the assumption that they are already institutions. If we assert that organization is taken for granted once it exists, we cannot distinguish the micro-processes".

THEORETICAL FRAMEWORK

WHAT, HOW, AND WHY

Overall, the theoretical framework employed is heavily inspired by Czarniawska and the original translation work. That said, the aim is not to prove/disprove existing theory, but rather use it as a stepping stone towards greater understanding, and seek to generate new discussion; viewing institutionalization as a process, rather than an outcome.

In other words, this paper does not only want to observe how ideas are spread (diffusion), or reshaped (translation) over time and space, but also expand upon the tentative answers to how and why this process occurs. The latter is, in part, inspired by Røvik's work on creating an instrumental theory of knowledge transfer as translation (2016). Furthermore, the framework is taking into account some newer developments within the field, whilst returning to the thoughts in the original texts; borrowing from the concepts of power and sensemaking, both of which have been called for within institutional studies (Covaleski et al., 1993; Greenwood et al., 2008). The chronology of the framework presented below is similarly followed in the discussion section.

As we are studying the spread of a management idea, the concept of management fashions, as espoused by Abrahamson (1991, 1996) and Abrahamson & Fairchild (1999), exhibits the overarching phenomenon. However, much of the research on fashions, as perceived by the researcher, is based upon rather broad-sweeping, quantitative studies, tracing concepts' usage over time. This results in little explanatory power as to the dynamics of change, as it mainly examines a binary adoption or rejection.

Instead, this paper is inspired by a more fine-grained, tentative model by Røvik (2011), expanding upon the fashions concept, likening management ideas to viruses. Røvik noted six major features of viruses: infectiousness, immunity, replication, incubation, mutation and dormancy; with ten corresponding idea-handling processes: adoption, non-adoption, isolation, expiry, rejection,

entrenchment, maturation, translation[7], inactivation and re-activation. That said, in its usage within this paper, the metaphor and the idea of a variety of organizational responses (linking to mainstream neo-institutional theory) are in primacy. Please note that the likeness is not meant in any normative sense, but rather used as it gives more food for thought and can serve as an enabler for discussion.

That said, an idea is not spread by itself. By necessity, people, often via organizations, are the ones promoting and/or leading change; actors who carry agency. I.e. institutional entrepreneurs. However, the study quickly showed that it is not down to a single actor, but rather a network of actors – sometimes even highly loosely linked. One recent development within the translation school is the metaphor of emerging institutions as anthills (Czarniawska, 2009), which this researcher would argue can be likened to a post-heroic (cf. followership in the leadership literature) take on institutional entrepreneurship.

Tying into this, but not limited to, we thus set the base-level premises of what we are witnessing: multiple actors[8]; with individual agendas (similar to Latour's "scripts"), capable of self-determination (cf. "logic of consequentiality"), whilst subject to social norms (cf. "logic of appropriateness"); creating together, wittingly or not.

"One should not underestimate the interpretive and creative capacities of actors"
– Galaskiewicz, 1991 (cited in Sahlin-Andersson, 1996)

With agency comes power; a concept speaking of the capacity to enact change in a social environment. Furthermore, this is what the actors studied (elites/influencers/people held accountable/decision makers) are highly capable of, and even claim to be using/try to use. Although the idea did not originate from there, this ties into an institutional study of DRG[9] (Covaleski et al., 1993), which attempted further integration power within institutional theory by viewing institutionalization as a process, leaning heavily on Clegg, and his thoughts on "disciplinary practices" (1989). Notably, the concept of power was also present in the work of the Scandinavian translation theorists (Czarniawska & Sevón, 1996). Rooted in Callon, who viewed power as central to translation (1986), and Latour (1981), they viewed it as the process of micro-actors associating, creating more powerful macro-actors, in turn changing the micro-actors through e.g. affecting market behavior (Czarniawska & Sevón, 1996); causal loops if you will.

At any rate, in 1974, Lukes identified three faces, or dimensions, of power: decision-making, agenda setting, and manipulation. The latter of which – rule through defining the rational (cf. Flyvjbjerg, 1998) – rhymes well with institutions as a regulating factor of social behavior; in other words, power over norms equates to power over institutionalized behavior. This brings about the notion, that perhaps management ideas have an instrumental capacity; a potential to function as power tools.

[7] Notably, this researcher would argue that the sociology of translation is broader, but this implies the process of translation incurred during its contextualization

[8] In this case, Sweden's healthcare sector is seemingly rather limited in size, limiting the number of actors, thus increasing the relative importance of each in turn.

[9] Which to some extent is a precursor to what is studied herein. More on this later.

"Whether theorists choose to interpret this scenario as evidence of organizational culture, institutional control, or the exercise of power and politics, at the core lie processes of sensemaking."
– Weick, 1995

A concept that speaks of the mechanism behind this function is sensemaking (Weick, 1995) – how we identify phenomena and formulate understanding, our concept of truth, of cause and effect. Or as Feldman said, the interpretive process by members of an organization "to understand and to share understanding about such features of the organization as what it is about, what it does well and poorly, what the problems it faces are, and how it should resolve them" (1989). In synthesis, should one strive to use a management idea as a power tool[10], the key performance of translators, in the process of contextualizing an idea, thus becomes transforming, disseminating, and reifying it, with the overarching aim of affecting, without breaking, the local sensemaking apparatus.

In summary, seeking to explore how this management idea was translated into a Swedish context, the line of reasoning is the following. The dissemination of management ideas and the creation of management fashions is a form of knowledge transfer, which results in a variety of organizational responses. This is led by a multitude of actors, who seek to, and are capable of using it in the pursuit of their own agendas, not least through its capacity to define the rational – the result of which is dependent on its contextualization, through a process of translation.

[10] Which is not unlike Focault's regimes of truth (e.g. 1977), with power-knowledge (which can roughly be equated to the power of data) and self-disciplining behavior.

METHOD

DISCOVERY AND CHOICE OF SOURCE MATERIAL

Given that the industry was novel to the researcher, and the specific circumstances of the case unknown, whilst subject to fierce debate, an exploratory research mode was chosen. To some extent, the method was akin to grounded theory (cf. Czarniawska, 2014), at the very least in spirit. Whilst any researcher clearly has preconceptions in terms of theory, and a well-developed capacity for industry-spanning analogies, a conscious choice was made not to dig deeper into a theoretical framework beforehand, but rather to set out inductively. Furthermore, a large body of knowledge was still unknown. Despite the buzz in the media, the guess was that it was far from all-encompassing, given its propensity to cry wolf and finding scapegoats (cf. media logics in Petrelius Karlberg, 2008), necessitating an open problem identifying approach, to gain a holistic perspective on the phenomenon.

As that the mode was inductive, with no intention of testing pre-conceptions, and no data sets of quantitative data readily available, any serious option of performing a quantitative study was eliminated – in line with viewing institutionalization as a process, rather than an outcome. Although some, highly interesting, translation studies (e.g. Zilber, 2002, 2006) are based on quantitative data, their empirics contribute little understanding of the micro-processes involved.

Thus, the study started with an open problem identification. This was an exploratory process where the first couple of interviewees helped guide the researcher through the field. Simultaneously, any potential points of interests or conflicts, based upon previous research, or any tell-tale signs in the interviews, were noted and continuously questioned. As the research progressed, now having a greater understanding of the situation, the research question was narrowed down, and more clearly delimited. This in turn led the interview questions to become more specific, seeking to contrast and clarify various perspectives; seeking clarity and elucidating question marks. This was also the point where theory became more apparent. Having an initial grasp of the phenomenon, it became a useful raster in the search for explanatory power. It was also useful introducing it at this point, rather than at the end, if one were to follow a strictly inductive approach, in order to inform the researcher of possible dead ends, as well as open vistas, before the last set of interviews.

The new data collected consists of fourteen interviews with twelve interviewees (see appendix for the full list). The interviews were in-depth and semi-structured (Czarniawska, 2014), targeting a cohort of mainly board members, management team, and consultants, typically spanning 45-60 minutes each, with two exceptions on the short side, due to time constraints, spanning slightly below 30 minutes. Per Shapiro, an investigative journalist (listed), who had conducted the two particularly insightful reports on the matter; an anonymized IT consultant, acting as a project leader; Ragnar Lindblad, of Sahlgrenska University Hospital, who has formerly been the MD of an IT consultancy focused on healthcare, as well as IT director of another hospital in Stockholm; Hanna Emami, the CEO of ICQ, the company in charge of the employee surveys; as well as individuals with a high degree of insight (not listed), were also added to triangulate the findings, as well as discuss the field in general terms. Some of the interviewees have also had multiple roles (listed in appendix), which contributed to their comparative power.

Supplementary data consisted of a wide reading of articles and reports by Swedish press, given the contemporary nature of the phenomenon; as well as investigations; statements and debate articles; articles in academic journals; strategy papers and presentations; recorded lectures, interviews and marketing material, with an emphasis on statements by the key stakeholders; as well as attending relevant seminars at the Swedish politician's week in Almedalen.

The rationale behind the choice of interviewees was two-pronged. Firstly, the aim was to elucidate the area from multiple perspectives, covering a broad spectrum of stakeholders on an inter-organizational level. The stakeholders were for the most part covered in the interviews, but in the case that the stakeholder had already published material deemed sufficient to understand their standpoint, they were not approached for an interview. This was in part also due to access and time constraints. Focusing on a single stakeholder would also have resulted in a vastly different study, revolving around the perception of a single organization, and less on the overarching turn of events, and the anthill perspective. Secondly, the interviews took place on an "elite" level, for several reasons. First and foremost, this is the level of the decision-making units, shaping the course of action, the key influencers; secondly, as this is an exploratory study, overarching perspectives were premiered, as they serve to give an introduction to the topic at hand, linking to the macro-level emphasis; thirdly, from an access standpoint it was counterintuitively easier to reach out to them, in part because the responsibility areas and mandates were clearer (thus aiding in their discovery), in part because that is where the network of the researcher led, and in part because of the fact that Karolinska University Hospital seemed to have been rather repressive towards its members of staff when it came to speaking to members of the press; fourthly, from a societal perspective, to discover, and bring to light the view of the managers, who for the most part have not been heard, perhaps in an effort to shy away from the public ire.

In some cases both members of the board, and members of the management team were interviewed, due to their distinct separation of duties. Overall, efforts were made to target the people who were directly involved, with an emphasis on the decision makers, and barring that, their successors, which in hindsight seems to have been accomplished. That said, it is not always that the interviewees were the decision makers, but if nothing else, who, as a result of their role and proximity, spoke from an informed position. In fact, it was notable how interviewees seemingly had a propensity to speak more freely on matters where they themselves were not the key decision-maker, be it due to political concerns or having had some time and perspective to analyze the situation, which lends credence to the stakeholder approach.

Unfortunately, not everyone was targetable for an interview. This was especially prominent for the historic perspectives, which were rather difficult to reach. In the end, it was a matter of access and prioritization. Additional interviews from each stakeholder might have led to more intra-organizational insights, yet now, most stakeholders ended up being covered either in an interview, or material they had published, which is consistent with the emphasis on inter-organizational perspectives.

The result of the data-collection was a direct route to the subject matter, and a holistic perspective on the variety of actors, agendas and actions central to the contextualization of the idea, which would have been neigh unattainable using solely existing public data.

ANALYSIS AND PRESENTATION

The analysis deviated somewhat from that typically used in grounded theory (Czarniawska, 2014). Here, a choice was made, not to fully codify and subsequently categorize the findings, but rather build a form of referential web. A cluster analysis of sorts, where possible hypotheses and tentative linkages were developed over time, in line with the exploratory mode.

The results are presented in a narrative form, largely tracing the travel of the concept, with the aim of providing richness of content and description, due to the subject's novel empirical nature and the surrounding societal interest, as well as a matter of methodological fit (Edmondson & McManus, 2007; Weick, 1995). That said, the results presented are but one aspect, and thus, the aim of the researcher is not all unlike that of a truth-seeking painter (cf. Prokopenko & Huston, 2017).

Whilst the results are presented with a largely chronologic structure, the discussion section rather follows the order of the research questions; sharing its structure with the theoretical framework. In other words, moving from travel, to actors and agendas, to organizational responses, to power, to sensemaking; or more broadly speaking, outlining the what (overarching process and outcomes), how ("micro"-processes), and why (instrumentality and implementation).

RISKS OF BIAS AND MITIGATING ACTIONS

The first and primary risk category is the data itself. To reduce the risk of self-serving bias, be it due to choice-supportive bias, rationalizations, politics, fear of reprisal, and networks, as well as of potential attempts at steering the interviewer, among the data sources, which is commensurate with both constructivist and critical realist perspectives, a number of measures were made to triangulate the data. To achieve this, a mixture of data sources, from various stakeholders have been used, to formulate the action net (Czarniawska, 2004) – i.e. the actors, agendas, and actions – central to this study.

The second risk category is that of its collection. General themes were developed over time, and cross-checked with previous statements. Thus, interjections and agency on behalf of the researcher increased. Whilst this process was useful in developing a deeper understanding, and by itself triangulated the data, it also involved some risks. Firstly, one may become trapped, or should one say, overly guided, by the first set of interviews. Secondly, one may be misled by one's own sensemaking; overly steering the interviews, digging deep into shimmering potential causal relations, and in doing so losing touch with reality. Mitigating actions include the mentioned stakeholder perspective, with a firm emphasis on discovering additional sources independently, and keeping an open yet critical mind throughout, whilst gladly winding the pieces of string made apparent in the interviews. Furthermore, having a rather early chat with an investigative reporter on the topic, and maintaining a healthy, scientific distance to the subject, also proved useful in keeping tabs on the data.

Another key action was the exchange and cross-checking of data (whilst keeping anonymization intact) with a simultaneous research project by Mosa Alasaly, at the department of political science at Stockholm University. In effect, this expanded the interview sample by three (see appendix), now totaling fifteen, and provided an additional intra-organization perspective, from the thematic heads of Karolinska. To avoid mutual bias or overly influencing the research process, the actual data exchange took place after close to all interviews had been completed by both parties.

Lastly, nearing the end of the study, some member checks were done, with integrity, to discuss the findings in depth, which provided additional information, and enabled further verification of the results.

ISSUES FACED AND RESEARCH ETHICS

The subject matter was a highly contentious and ongoing event. In one case, this led to high-profile leaks of a role-change the day before an interview with the involved individual. By virtue of the topic's sensitivity, close to full anonymity was demanded in one case, but in all cases offered, but rarely deemed necessary. That said, some quotations were anonymized in posterior, as a matter of research ethics. Some information was also given strictly off the record. Although unfortunate for the scientific pursuit, the information was still highly useful for the research process, in part by aiding the triangulation of the findings.

The interviews themselves could also be a challenge, in the search for quality information. Differing levels of political polish were met, which can entail somewhat ethereal descriptions. The interviewee, or rather, the very concept of the interview, may seem threatening, by virtue of the subject matter. Luckily, the researcher's role as a student likely lessened the perceived threat level, enabling greater data access. There was also the social element, whereby the researcher by their individual interaction may influence the quality of the interview data. Furthermore, some events occurred several years past. Although this meant that some elements may have been difficult to recall in detail, yet, time also seemingly implied greater freedom of recounting. Lastly, this was a neigh completely novel industry for the researcher, which entailed learning new vocabulary, and industry dynamics, which, although an exciting process, and potentially enabling an outsider's perspective, also posed a challenge in the first couple of interviews.

It should be noted that the research process of this paper began in February 2017, with a majority of the paper being completed by May, with the last touches in August. In late August, the same year, the researcher began his employment at a management consultancy, who are in the same profession as BCG. No other conceivable conflicts of interest exist.

GENERALIZABILITY

The case is perhaps not the most common, and it is but one case, and the description tracing the chain of events is largely in a narrative format. Yet, as Weick said (1995), in these types of studies "Density of information and vividness of meaning are as crucial as are precision and replicability". Studies, which commonly operate "under the assumption that person-situation interactions tend to be similar across classes of people and situations", where the "Settings are chosen more for their access to the phenomenon than their representativeness". As does this.

That said, this study seeks to chart the unknown, in terms of both empirics, and theory – the latter, at least in its combination. Thus, armed with a provisional theoretical framework, the study ventures into territory arguably somewhere between nascent, and intermediate theory (Edmondson and MacManus, 2007), with the aim of drawing a map outlining a great unknown, with some early attempts at more detailed exploration. A map, which can then be further detailed, colored in, built upon, analyzed, compared, and hopefully inspire researchers to come – if nothing else, then by its very attempt.

RESULTS

This is a story of how Value based health care delivery[11], henceforth called "the concept", has been translated into a Swedish context.

ORIGINS

The concept is the brain-child of Michael Porter & Elizabeth Teisberg, at Harvard Business School's Institute for strategy and competitiveness in Boston. The seemingly first budding traces of the concept could be seen in the articles of Porter and Teisberg in Harvard Business Review in 1994, "Making competition in health care work", and 2004, "Redefining competition in health care", respectively. The firmament came in 2006, in the book "Redefining health care: creating value-based competition on results". That said, subjecting it to a closer look, it isn't a stretch to say that much of its DNA can be attributed to multiple sources. In fact, the basic premise in this paper, which must be established to properly understand it, is that it is an umbrella concept. An amalgamate of ideas brought together in a strategy to solve a specific, albeit systemic problem: the spiraling costs of healthcare in the developed world, and more specifically the United States.

"The U.S. health care system is in crisis. At stake are the quality of care for millions of Americans and the financial well-being of individuals and employers squeezed by skyrocketing premiums—not to mention the stability of state and federal government budgets."
– Porter & Teisberg, 2006

$$\frac{Health\ care\ outcome}{Cost\ of\ care} = Value$$

Speaking about the concept with its proponents, the equation above is often the first piece of scripture written on the closest whiteboard (as seen, dead center, on: HBS, 2017). Value in the concept is defined as "patient health outcomes per dollar spent", in other words, a utilitarian measure of efficiency, where the "patient is at the center". Now, this doesn't amount to much in singularity, as the interviewees said "It is self-evident that we have to work like that… It is a rather easy pitch" (Lindblad), "The core principle itself is difficult to question" (Gaunitz).

That said, the concept in its totality is much broader. The foundation is firmly based on competition, seemingly with an emphasis on the cluster analysis made famous by Porter, which arguably has a lot of overlap with experience curve effects. In other words, "A trade-/economic based steering model", assuming "…economics as an important steering device" (Lindblad). Tying into this, the argument is made that healthcare providers should specialize, building essential expertise by "concentrating volume by medical condition" (cf. experience curves), and together build networks of healthcare delivery to facilitate the division of labor (i.e. covering all medical conditions). Thus, the argument is made, that health care providers should not grow in the wealth of their services but in the geographic reach of their area of competence (i.e. expanding their uptake area to find scale).

[11] Swedish: Värdebaserad vård

"The fundamental goal of economic policy is to enhance competitiveness, which is reflected in the productivity with which a nation or region utilizes its people, capital, and natural endowments to produce valuable goods and services"
– Porter, 2009

In "The case for bundled payments in health care" & "How to solve the cost crisis in health care" (2011, 2016), Porter, and his colleague Robert Kaplan (now listed as faculty in the curriculum on value-based health care delivery, HBS, 2015) explained the payment model in further detail; in essence, a step towards operationalizing the concept. In summary (with additional information from seeing, in practice, in a technical solution developed by IVBAR[12]): the reimbursement of health care providers should be based upon the cost of "the full care cycle"[13], as defined by an activity based costing approach (for which Kaplan is especially known); with an additional reimbursement built in as a form of risk premium, given the difficulty of the care cycle as well as the demographics of the person, such as age (also known as a "case-mix"); as well as the health care outcomes of the patient, notably including, among other things, quality of life measurements, i.e. akin to a balanced score card[14] (another one of Kaplan's ideas).

This implies a continuation of the previously commonly used reimbursement of volume, but with additional performance incentives in two aspects: quality improvement (e.g. quality of life measurements) as well as failure avoidance (i.e. a pre-made risk premium, putting the onus of quality of care on the health care delivery provider, rather than the procurer), as well as a potential cover for difficult cases via a higher incentive for complex procedures. The thought is that this should alleviate the "focus on volume" in the existing fee-for-service system known as DRG[15], raising quality (where quality of life measures is a novel approach, compared to the strictly clinical measures more commonly used) – in the official descriptions termed "positive-sum competition" (HBS, 2017). It should also remove the incentive for failed care (as the former system in practice implied that a health care provider could repair the same hip fifteen times, failing fourteen times, and get fifteen times the payment, which is now replaced by the risk premium), whilst, hopefully, avoiding the cherry-picking of 'easily fixed' patients by providing a higher reimbursement for the most difficult cases.

On a more operational level, by extension, this should also help "break down silos", by stimulating the formation of so called "integrated practice units" (IPUs) – in essence a 'patient centered organisation', with one unit having full responsibility for the full care cycle as well as any extra/supporting services. Further operational advances espoused in the concept are "systems integration" (i.e. the networks of healthcare delivery mentioned above) and building an "enabling IT infrastructure" (i.e. standardizing and aggregating data, in order to facilitate the strategy) (HBS, 2017).

[12] Ivbar Institute AB, a Swedish business intelligence company founded in 2012. More on them later.
[13] Swedish: Vårdepisod
[14] Score card in Swedish: Styrkort
[15] In Sweden applied as DRG-Nord

"We need to measure how it goes for the patient. If we do not measure, we do not know what works or not. That is value-based health care"
– Stefan Larsson (Shapiro, 2016 b)

A key, if not the most important one (Larsson), to all of this is measuring outcomes. I.e. the qualitative measures of the balanced scorecard, and the creation of the data on which public choice, benchmarking as well as 'data-driven' internal quality improvements can be based. The astute reader likely notices the resemblance to DMAIC (Define, Measure, Analyze, Improve, Control) of Six Sigma – a framework for continuous improvement. Thus, one first has to define what to measure, and in healthcare there are a great number of diagnoses, procedures applied, care outcomes and related data.

Rationalizing this is no new task, and there is a wealth of registries out there. In 1893 the International List of Causes of Death was adopted by the International Statistical Institute, which was taken over by WHO in 1948, as it was established. This has since been developed into ICD (International Statistical Classification of Diseases and Related Health Problems), which is now at its tenth edition, and undergoing revisions for its 11th, providing an international base-level codification of diagnoses (WHO, 2016). At Yale University in the 60s, these were utilized as the baseline in devising DRG (Diagnose Related Groups); in essence, a hierarchy based approach to group diagnoses and procedures (Socialstyrelsen, 2015). A third level categorization of this is MDC (Major Diagnostic Categories), whereby the DRGs are divided into organ or etiology, which widely overlaps with the medicinal specialties (e.g. "Ear, nose, mouth and throat").

DRG was, pre-emptively, created in order to be able to tackle the spiraling costs of healthcare in the US, by laying the foundation for a fee-for-service based system, where the health care provider is paid based upon a set sum for each DRG. The system is now widely implemented across the Sweden (Socialstyrelsen, 2016), replacing the old cost/budget-based system[16], which its critics argued lacked comparability and didn't incentivize cost efficiency (since it didn't promote profit seeking behavior). Furthermore, even if not used as a direct payment model, it also arguably meant that the health care procurer gained bargaining power when determining the budget, now being able to track the procedures used as well as refer to a standardized system for reimbursing them.

Now, following this tradition of healthcare definitions, enter ICHOM (the International Consortium for Health Outcomes Measurement), a non-profit organization with the stated purpose to "transform health care systems worldwide by measuring and reporting patient outcomes in a standardized way". The board consists of four listed founders: Jens Deerberg-Wittram[17], Executive Director, BCG; Michael Porter, HBS; Stefan Larsson, Senior Partner & Managing Director, BCG; Martin Ingvar, vice principal, Karolinska Institutet. This highlight of Karolinska Institutet as a founding partner resonates across a number of other materials by BCG and ICHOM. Conflictingly, ICHOM's FAQ, in 2017, states that it was founded in 2012 by Porter, Ingvar and BCG . Furthermore, in one of the interviews, it was clearly stated that the initiative to start ICHOM came from Stefan Larsson and Michael Porter, and

[16] Swedish: Anslag
[17] Also, senior fellow at HBS, at the institute for strategy of competititveness

not from Karolinska Institutet. That said, ICHOM is making an effort to develop their own standard set, not dividing by organs (i.e. MDCs), but by patient groups and commonalities of treatment (i.e. patient flows), whilst including a set of customized care outcomes for each flow (e.g. one set has the main categories: survival, morbidity, patient-reported health and well-being, patient satisfaction with care).

> *"ICHOM's mission is to unlock the potential of value-based health care by defining global Standard Sets of outcome measures that really matter to patients for the most relevant medical conditions and by driving adoption and reporting of these measures worldwide."*
> – ICHOM, 2017

With eyes fixed on devising a global standard set for quality measures, the question was: where do you start? The answer, it seems, was Sweden.

FERTILE SOIL

In 1975, Göran Bauer, a Swedish orthopedic-professor, started the first Swedish quality registry in Lund (Nationella Kvalitetsregister, 2016), which targeted knee prostheses, as the technology was still in its infancy, with a large variation in technology and quality. In 1979 a similar registry was created in Gothenburg, targeting hip prostheses. Interestingly enough, he had recently come home from Harvard, where he had spent several years. Harvard was also the alma mater of Amory Codman[18], a pioneering surgeon in the early 1900s who had propagated for what he termed "The End Result Idea". In essence, doing longitudinal studies measuring patient outcomes, and then having regular meetings among the doctors to analyze, compare and then publish the results. That said, having trialed the model and found that only 89 out of 692 hospitals delivered what was deemed acceptable care, the health care elite burned the entire documentation, and he was largely shunned by the Harvard medical community (Nationella Kvalitetsregister, 2016).

Fast forward to 2009. Sweden had since long shifted from the old cost based reimbursement model to one based on a DRG derivative, called NordDRG (Socialstyrelsen, 2016), as part of the wave of New Public Management (NPM) that hit Sweden around the turn of the millennia, where, by and large, competition was introduced in order to stimulate cost control (i.e. highly similar to the rationale in the US). Even so, Stockholm County[19] (SLL), was in dire need. The public healthcare system had queues for hip and knee replacements that were through the roof, reaching upwards two years (Ljungberg Schött). The answer they found, around the time BCG hosted a noteworthy seminar on the concept – "we were thinking about a design, and it happened to overlap" (Ljungberg Schött) – was opening up for private health care providers (i.e. choice of care[20]) through a payment model based on outcomes (i.e. a form of bundled payments). The irony is palpable.

[18] Codman, together with Florence Nightingale, laid the basis for what is now known as "evidence-based medicine" (Nationella Kvalitetsregister, 2016)
[19] In the Swedish healthcare system, the counties are ultimately responsible for the provision of health care, and healthcare has typically been run through public bodies, rather than privately held companies
[20] Swedish: Vårdval

"This case illustrates that bundled reimbursement is not only feasible, but value enhancing. Stockholm's leadership provides an important benchmark to guide the design and implementation of bundled reimbursement globally."
– Porter (Wohlin et al., 2016)

Meanwhile, speaking with Stefan Larsson, "the ones who have probably worked the most with this [outcome measurement] are Capio". Capio[21] acquired St Göran's hospital in 1999 (Capio, 2017), as SLL were pushing for privatization. To the researcher however, it is still somewhat opaque as to when Capio started engaging in quality measurements. That said in 2006, SKL (Sveriges Kommuner och Landsting – a unifying body for the municipalities and counties of Sweden) & SoS (Socialstyrelsen) published the first report on quality and efficiency for Swedish healthcare, comparing the counties (SKL & SoS, 2006), as part of a strategy called "God Vård" (Good Care). Notably, as the chair of the steering committee you find Roger Molin from SKL, who in 2011/2012 was appointed "Vårdvalssamordnare" (coordinator for choice of care) (Mellgren, 2011), by the, then in government, liberal-conservative block "Alliansen". In January 2006, Capio's "initiator" and CEO, Per Båtelson, who later became the chairman of Karolinska University Hospital, together with Johan Wachtmeister, founded a new company, GHP (Global Health Partner).

GHP was started with the aim of creating "world-class" clinics, through a high degree of specialization (which is a distinct difference from the typical Swedish clinic), focusing on specific patient groups to reach scale and thus capabilities to attain high quality (GHP, 2017). Part of the team, "from scratch", was Jonas Wohlin. "We were contacted by Porter who needed case studies which… provide examples from reality, strengthening his thesis on how things should work" (Wohlin). This ended up in a case study on GHP's obesity and spine care demonstrating "the impact of volume on learning and efficiency, and the importance of demonstrating quality though outcomes reporting" (Porter, Yasin & Baron, 2009). Following this, Porter was reportedly ecstatic (Westin, 2016), as he had just heard that SLL had recently implemented a reimbursement model for all non-complex hip and knee replacements (as mentioned above), where all outcomes had to be reported to the Swedish Hip Arthroplasty Register (i.e. a development of the one from the 70s) (Wohlin et al., 2016), a system level implementation similar to what he had been propagating all along. This became Wohlin's PhD. thesis at Karolinska Institutet (which is still in progress). Wohlin et al. published a report analyzing the policy in 2016.

"Us working with these questions at Karolinska started the company IVBAR, because we saw a trend where healthcare is going from volume-focus to value-focus. Not in the form of reimbursement models, but in what the focus is in the management and steering as well as the operations. And then a number of things have to come in place to enable that transition. Opportunities to follow up and analyse value in a clever way is a prerequisite to drive the operations toward driving value, and another is that the reimbursement model does not

[21] Capio AB is a pan-European healthcare provider

hinder such a development"
– Wohlin

In 2012, Wohlin, together with his colleagues at Karolinska Institutet, started the business intelligence company Ivbar Institute AB, with Båtelson as chairman. Notably, the company largely consists of people with a background in engineering physics. The following year, at least two important developments occurred. Firstly, SSL decided to introduce another choice of care program, this time in spine care. In doing so, they also commissioned Ivbar to establish and maintain its bundled payment model. Sveus, a database/"analysis platform", was formed as a research project in cooperation between seven counties as well as the government (Sveus, 2017), "to enable value-based steering for Swedish health care" (Ivbar, 2017), following the initiative of Roger Molin and Alliansen.

"We experienced that the progress [of introducing choice of care] was partly held back by insufficient reimbursement models. Stockholm had found something new and interesting. Then the idea was born to gather the counties to develop new systems"
– Molin (Vårdfokus, 2016).

Sveus connects various registries, including quality registries, as well as the demographic data of SCB. Furthermore, it cooperates with ICHOM in defining patient groups & the respective health outcomes (ICHOM, 2017b). Sveus, in contrast with "Öppna jämförelser", looks at individual hospitals, and involves a more extensive case-mix than what has been used before (Båtelson); in essence, now using a multivariate model trying to account for demographic differences. The latter is especially important, given that this was one of the primary arguments against the validity of the previous comparisons made, on behalf of the doctors (Båtelson). I.e. the outcome was, a benchmarking tool for primarily quality, across the connected counties; as well as supplementary management dashboards, illustrating the patient flows, incurred costs as well as profit centres, using an activity based costing approach. Sveus was operationalized in 2016, when Uppsala Academic Hospital were the first to connect.

Notably, the analysis tool developed, as part of Sveus, is based on the collected data, but no data leaves the system. The business for Ivbar is rather in establishing which data points to use, how it interacts, and formulating the code of the tool itself (Båtelson; Wohlin). The tool can then be used as part of an international expansion; whereby other countries connect to build their systems.

"In moving to a value-based system, a key enabler is shifting to bundled reimbursement"
– Porter, *(*Wohlin et al., 2016)

"With shared vision and a coherent national strategy, Sweden could build world-leading platform in value-based healthcare within 10 years"
– BCG, 2009

In summary, Sweden had a rich history of working in ways similar to the Concept, in part, through its history of extensive and longitudinal collection of data, where many quality registries have reached global recognition (Larsson). That said, although extensive, they were still rather fragmented, which was a key issue in their usability (Ivbar, 2017), and with Sveus as a form of collecting node, that

problem seemed to be on track to be alleviated. In part, the concept of using bundled payments as a steering system, had also started to be employed in the Stockholm region, seemingly for the first time on a systemic level, where the debate on care choice between the right and the left has arguably been particularly fierce. However, when it comes to the operations of healthcare, little seemed to have been done to integrate the full spectrum of the concept (Lindberg; Shapiro, 2016).

And then, opportunity presented itself.

THE GOLDEN OPPORTUNITY

The exact turn of events of the strategy formulation at SLL in regards to Karolinska are somewhat opaque, and most of it is not related to the purpose of this paper, but the study showed the following. In 2008 a new organization was formed for NKS, led by Lennart Persson, which was split from the administration of KS, in order to let it run freely, and avoid political issues within the organization (Gaunitz). This was then reintegrated with KS in 2011, as the organizational changes drew closer, and a disassociation no longer feasible. Following "a great number of study trips… to the US in particular", among them to Intermountain Healthcare in Salt Lake City, to see their appliance of value-based payment models, as well as to attend lectures by Porter (Gaunitz), a pilot project on network health care was initiated, led by Tomas Mövin at Södersjukhuset in Stockholm. And then, the heading of the strategy seemed set.

In 2011, "Framtidsplanen" ("The Plan for the Future") was presented by the Moderate (a liberal-conservative party) led SLL, which has since then been expanded upon with two consecutive additions (SLL, 2011, 2013, 2015). The aim was to do a holistic take, and create "a cluster of knowledge" in the north-western part of Stockholm city, replete with life science companies and research activities, and at the heart of it all (Ljungberg Schött): the crown-jewel, new Karolinska University Hospital (aka NKS). The emphasis was on creating "the absolutely most modern" in practically every dimension, including the organization (Ljungberg Schött); building "future-proof" (Anonymous). The owners, LISAB (the administrative body of SLL) had two major directives for the NKS management: 1. "Network health care" (Nätverksvård), and 2. "Level-shift" (Nivåskifte) (Ringman Uggla; Gaunitz). In summary, the espoused strategy, on a systems level, involves moving less complex cases to lower cost areas (from the hospitals to e.g. clinics and primary health care providers), "something people are trying to do everywhere in healthcare" (Gaunitz); a decentralizing move which stands in stark contrast to the strategy from earlier days, where scale (and likely quality) was achieved by centralizing healthcare in the hospitals. At the same time, the level-shift implies a higher degree of focus on the most complex of cases, i.e. a higher degree of specialization (Ringman Uggla; Gaunitz). In effect, this means that by the end of 2018, when its aimed to be implemented, having seen some delay (Ljungberg Schött), in order to enter the ER you need a referral. Tied into this is the so called Rikssjukvård ("national healthcare"), whereby certain specialties may only be found at maximum two locations in Sweden simultaneously, in order to centralize key talent. I.e. it is cheaper to put someone on a plane than to build a new high tech care facility.

"We had an opportunity to change our way of working"
– Samsom

As it turns out, one interviewee remarked that Karolinska is "a university hospital with a very strong self-image". In fact, a member of the administration remarked that it had "a culture that is not

aligned with its intent… [and the reorganization] is a way to break it apart". In order to drive the change they thought was necessary, SLL, LISAB and the management of KS (Karolinska University Hospital) decided to "stick together" (Anonymous). Furthermore, a decision was made to do it tandem with the change process incurred with moving to the new facilities, to avoid two lengthy change processes after another, as well as seemingly utilize the change of facilities as an impetus for change.

A key change agent was Per Båtelson, who in 2013 was welcomed, as chairman of KS, "to SLL in a time of extensive development and change in healthcare – not least at Karolinska University Hospital. I also think Per can contribute additional energy in our cooperation with Karolinska Institute and what we together need to do to raise the quality of care to the highest international level" by former county director, Toivo Heinsoo (SLL, 2013b). Tellingly, they now hired a chairman, who had been the CEO/chairman of the organizations in Sweden with perhaps the most operational knowledge of/similar to the concept (as seen above), who was also from the private sector. Perhaps even more noteworthy, is their common view of outcome measurement.

"If you change the incentives, then change will inevitably happen"
– Båtelson

"Rigging the deck"
– Anonymous

One of his key tasks was to hire a new CEO, as Birger Jakobsson, who was a major proponent of lean (Delaryd, 2013), was retiring. Enter Melvin Samsom, professor of gastroenterology, with similar experience of outcomes as a change tool (as seen in Läkartidningen, 2014) from running Radboud University Medical Center in the Netherlands, with reported great success (ibid). The key words had been transparency and patient cooperation (Läkartidningen, 2014). The hospital was also the first hospital in the Netherlands to publish its outcome data. At any rate, Samsom was seemingly seen as 'uncorrupted', a white knight; a third party with virtually no connections in neither healthcare Sweden nor among the management team at KS (Båtelson). It wouldn't be far fetched to say that the latter was, at least in part, a tell-tale sign of, or even a necessity for the wide sweeping organizational changes to come.

Up until then, BCG had been trying to establish a foot in the door (Shapiro, 2016 b), but had yet to succeed, in one case even going so far as to offer a free consulting project. The previous hospital management, however, had been reluctant to adopt the concept as an organizational model, rather emphasising their existing efforts to implement lean thinking in the organization (Wohlin). "He [Stefan Larsson] made repeated attempts, but I never grasped what value-based health care had to offer in extension of what we were already doing", said Jakobsson (Shapiro, 2016 b). But, now, the planets seemed to be aligned.

That the consultancy viewed this as an important, if not landmark, deal was abundantly clear: not only in the initial free project, which Larsson said was "an investment from their side", but also in a price dumping in the ensuing bidding process (Shapiro, 2016 b). Furthermore, around the same time, BCG published "The value-based hospital: a transformation agenda for health care providers" (2014). This would be the first time that someone would seek to operationalize the concept; as is clear in

Samsom's response, when asked about its credence, "The new organizational structure is focusing on solving this step by step. Let's come back to this in one or two years and we can show you the results." (Shapiro, 2016).

THE DEVIL IS IN THE DETAILS

"Measuring outcomes is a complex and long-term endeavour. Implementation can take a year or more and require additional manpower, technology, and resources."

– ICHOM, 2017c

"To get this to work for real… we have to organize thereafter"

– Anonymous

The work on value-based health care at KS seemingly started with a pre-study, creating a scorecard based on outcomes for a specific part of the patient population. The aim was to validate whether it was possible to follow up on patients with the data they already have, including that which they are already feeding into the quality registers – which it mostly did (Anonymous). The study was led by Andreas Ringman Uggla, then at BCG, together with some other from the consultancy, as a research and development project together with the internal analytics. It seems likely this study was the one that BCG had offered free of charge, based on the time period.

The story goes that as the pilot progressed, as the clinics are partly autonomous, many of them opened their eyes for measuring outcomes. More became involved, and a broader base of support the concept was established, "it felt so right" (Anonymous). However, in one of the interviews, it was indicated that in the internal communication it was important that it was spoken of as a "concretization of the flow-work", and not the concept, to seemingly avoid reprisal. Similarly notable, in regards to the internal communication, is the use of the word "themes". Several years earlier, people had been speaking of 'thematic healthcare', yet "one shouldn't speak about the word theme", and now, interviewing the CEO, he was clear to speak of themes as opposed to IPUs[22], and say that the structure had been an internal development.

With the change in management in 2014, a steering group was formed, and change quickly ensued; the concept was now the way forward. The goal was that by 2018, when they move into the new facilities, 80% of the patient population would be in the new system (anonymous; Ivbar, 2016). That said, now also began the work on creating the operational model/organizational structure (the two terms have been used interchangeably by most of the interviewees, but the difference was highlighted by members of management). That said, one interviewee noted, that even before the change process started there were many, sometimes acrimonious, discussions about how to organize internally.

By 2016, the implications of the concept had visibly expanded. In a lecture, together with Samsom on how they work with the concept at KS, Ringman Uggla now lists "four key components, together enabling what he terms a "value based healthcare improvement system": outcome measurement;

[22] I.e. differentiated by themes having shared technology (functions), as opposed to IPUs

costs & resource utilization measurement; patient flows & standardized care programs, "That minimize variation in practice, but at the same time make sure there is room for innovation" (note of the researcher: which is an eternal question really) (cf. BCG, 2015); and IT system support (as infrastructure & enabler) (Ivbar, 2016). Worth noting, he also highlights that the "rehab-chain with external parties requires monitoring outcomes across providers". Another organization also affected by the changes is Karolinska Institute, who will now adopt a structure corresponding to the new themes, patient areas and patient flows (KS, 2016), although if this goes further than acting as an interface for communication between the two organizations is not known.

He then goes on to list five components in how KS builds this system: patient groups, measurements of quality & cost, multi-professional teams & including patients, prioritization and continuous improvement based on the outcomes, and clear & consistent governance.

Regardless of this work, the major publicised change of NKS organization however was changing from the clinical structure (based upon the medicinal specialities, cf. MDCs), into themes, or IPUs (based upon the patient flows), although the latter word was not used by the management team[23]. Remarkably, this was initially associated with the concept, as seen in marketing videos from Karolinska, as was echoed in the interviews, but a press release, updated February 2017, now says "the point of origin in the developmental work Karolinska University Hospital is now performing is 'Patient first'". Worth noting, the new patient flow management teams also imply that nurses are in the same management teams as doctors, and now also invite patient representatives.

The previous work on lean, which had a significant history in the hospital, still had an important presence. Uggla spoke of Lean as a "toolbox" to work with patient flows, but, on the other hand, Lean is notably, at its core, a philosophy on quality improvement and continuous change, which Larsson himself emphasized.

"There was no conflict between Birger's flow strategy [Lean] and value based healthcare"
– Anonymous

One interviewee noted, that there was no contingent need to reorganize to work towards measuring patient outcomes. Rather, the activity based costing seemed to be the most important driver of the organizational change, in terms of contingency. Given the change in accounting practices, it was seen as "logical" to organize thereafter. Furthermore, they remarked that between Lean and the concept "it is not that big a difference, only a bit different packaging", and that in the Thorax clinic they already practically had an IPU. In line with this, Lindblad noted, that "it is not only that you change, but you trash-talk the old". He added, "It is like religions".

"Worst case scenario it won't be that different, but it won't crash and burn"
– Anonymous

[23] When asked about the difference, Samsom emphasized how technology is shared, what in the themes are called functions. At KS the functions are shared across the themes in a form of matrix structure, whilst an IPU is horizontal; owning its technology in full.

The overall change the interviewee above did see in practice though within KS, apart from IT and accounting-work, was greater participation, and thus a change in the power relation between nurses and doctors; increased degrees of freedom in planning, in essence making the lives easier for the managers; as well as a new variable to optimize, in other words, a change in what one is steering towards.

"We have always had the patients in focus. But be glad then, that management have come to, and are steering toward this"

– Anonymous

However, not everyone was happy.

HOUSTON, WE HAVE A PROBLEM

Despite proficient and diligent operational staff and the best of intentions, many, if not most, large projects seem laden with issues (Sahlin-Andersson, 1989; Flyvbjerg, 2014, 2017), especially in change projects, and Swedish healthcare and KS, are no different.

"Melvin probably has the most difficult job in Sweden right now"

– Multiple interviewees

ALL NEW, ALL AT ONCE

"[What we are doing here is] something unique… There is a lot of people watching this"

– Henrik Gaunitz

The overarching aspiration around NKS was that of the ultra-modern – building "future-proof" – as noted above. Furthermore, to alleviate the burden on the margin implied by the change, and give the administration room to settle in, a decision was made to change the reimbursement model back to the old budget model, as opposed to the DRG model, up until 2019 (Gaunitz). However, the flip-side of the coin was holding onto the costs.

A project leader's response, when asked about the procurement processes, was "oh my god". They argued that the procurements of NKS suffered from grave under-specification and were often covering a wide array of products and/or services at once, resulting in excessive price premiums from the suppliers. It also seemed as if NKS was largely viewed as separate from the rest of the operations of SLL. When it came to a telecoms procurement, this initially resulted in a cost for NKS as high as the rest of the county in total. There have also been multiple telling stories from the interviewees and my peers. One of them spoke of construction workers staining a sofa, and then, instead of cleaning it, tossing it in the trash and ordering a new one, no questions asked – and this was in the workers' barracks.

In the case of medical equipment, one of the interviewees said, which was later acknowledged by one of the others, the profession had essentially decided on their own equipment. I.e. resulting in the latest and greatest. This in turn has had seemingly far reaching implications, whereby the management team had to adapt to it in posterior.

On a more overarching level, there were also other issues. By and large, a significant gamut of the changes seemed to occur more or less simultaneously. Whilst this created significant uncertainty on

behalf of the analysts, it was even more poignant on the technical side. Everything was done just in time, seemingly in order to save costs. The question is if this wasn't a misdirected effort. As the technology acquired was more or less all brand new, as part of building "future proof", this meant that whilst everything had worked just fine when tested in isolation, no tests had been made of their interoperability, lacking a fixed point of reference. I.e. there was no technological backbone to set the baseline. The lack of slack also implied a shortage of time for learning and anchoring the change internally.

The importance, and difficulties of technical implementation, engendered by opting for the latest and greatest, seemed to be similarly forgotten in several instances. At a dress rehearsal at NKS, which ended in a fiasco (Läkartidningen, 2016): the technology (mostly telecoms) was in place, and for the most part worked just fine, the failure was rather in forgetting to hand out the lists with the contact details in advance (Anonymous). Furthermore, the challenges on the IT-systems implementation, implied by the plan to cover 80% of the patient volumes in the new system by 2018, was said to be "Alarming. How the heck are we supposed to fill up this need" (Anonymous). This has in turn been said to be a recurring phenomenon in other healthcare projects in Sweden, by an IT consultant with significant experience.

A QUESTION OF POWER

That said, the cultural issues which were said to be at the core of the change, hadn't disappeared overnight. According to Larsson, a significant problem, and an impetus for his interest, was the high staff turnover in Swedish hospitals, which was especially significant among nurses, reaching about 20% in some cases, with an "extremely stressful" environment and "people who don't feel well". This was echoed as a key issue by Båtelson.

"I don't believe squat of what is written in the papers anymore. […] Ultimately, this is about power. This organization gives less power to the doctor [as a profession]"

– Anonymous

A highly striking view is that many of the outcries in the media about the new organization are by and large a result of a battle of professions. More specifically, a deeply rooted power struggle built on professional pride and identity. Visible, among other things, in an unwillingness to involve nurses in a highly hierarchical organization; and now, nurses were made part of the management teams. The fact that the union representing the doctors have been one of the most vocal critics of the reorganization, with 89% of the doctors preferring to keep the former organizational structure (KSF, 2017), whilst the union representing the nurses has been in favor (Westin, 2016b; Dagens Medicin, 2016c), seems to support that thought.

One of the interviewees also noted that there was a large deficit of assistant nurses – and despite that, one refused to let in cleaning companies, rather letting the nurses (who have tertiary education) do all the cleaning. They continued, it is no wonder that they quit, especially the ones who are straight out of university. The experienced ones on the other hand were already hardened, and endured. Furthermore, this was argued to incur higher costs than if dedicated cleaning services would do it, in addition to engendering the already strenuous workload. When discussing the issue with a member of the profession, and being shown the responses in a social media group for nurses

to a related line of argumentation, it seemed as if there was a significant professional pride at play. The nurses didn't seemingly want to let others in, even if it would have helped themselves.

An alternative perspective, which was shared among many of the interviewees, was that many of the outbursts and critical stances taken by various organizations, one example being the recent criticisms of the concept voiced by the Swedish Society of Medicine ("the scientific organization of the Swedish medical profession") (SvD, 2016; SLS, 2016:2017)), were not the result of a shared sentiment in the profession or organization. Rather it comes down to individuals with their own private motives, "everyone knows that's what it is" (Anonymous).

DISENCHANTMENT, SENSEMAKING AND LEVELS OF DISCOURSE

Multiple interviewees argued that healthcare in Sweden has been run with an over-emphasis on processual control. In part, in the practice of Lean, despite its core philosophy of quality improvement.

"There is not a lean-project in Sweden that has used the "Öppna jämförelser"
– Larsson

This in turn, the argument went, had led to a widespread resistance to management and control in the organization.

One interviewee spoke of the lack of "participation" in the change process, and that most employees on an operative level had heard about a grand vision, but were met by lackluster workshops. Rarely, if ever, seeing the top managers face-to-face. Samsom himself stated that one of their key issues/weak points had been communicating in the change process.

"It felt pointless to sit in endless meetings and workshops. Management is trying to create a new model based on Excel sheets and diagnosis numbers, but there are many, and often essential connections which are not visible in numbers. The top-steering also makes you lose the strongest inherent motivator in healthcare, namely doing something for the patients, and sharing the resources in the best way, 'on the shop floor', every day."
– Korkeila, former Managing Director, KS (Shapiro, 2016)

The change was seemingly led rather top down, driven by Samsom and Uggla, with the new division heads as change leaders, supported by "change partners", HR, finance, and "Uggla's unit" (i.e. production – Uggla also acted as a liaison towards BCG). One interviewee spoke of "Dutch management culture", noting a cultural discrepancy with the Swedish consensus model, but remarked that, on the other hand, KS "likely needed a shake-up". This has been echoed by multiple sources.

"The mood is greatly affected, I think, by being fed with a language and Power-point presentations that are incredibly complex, which makes you simply become very tired and feel that you don't really understand what is happening. We very much have a lingo which I think is run by economists and engineers. […] It is completely incomprehensible! Look at it, no one understands anything! [scrolls through ppt slides] You see how many! It is completely insane!"
– Holm, Patient flow manager, KS (Shapiro, 2016 b)

Hearing Holm tell it, it seems as if the best analysts are not necessarily the best communicators.

HERE TO STAY?

"Value based health care is as close to a brand as you can come"
– Lindblad

What is evident in almost all of the interviews is the view of the concept as a management fashion; "Value based healthcare became a word a la mode" (Gaunitz). That said, one should probably be cautious in calling it entirely novel, not only as it is by and large a framework, a strategy built on multiple existing theories, but even more so in that the core concept itself bears a lot of resemblance to "the end result idea", as presented by Codman around the turn of the century. As a side note, the irony thus becomes rather salient, when seeing some of its staunchest critics arguing that the concept is not "evidence-based" (SvD, 2016; SLS, 2016:2017)), when it was seemingly originally proposed by one of the founders of evidence-based medicine.

"It is naïve to believe that it would be the solution to all our problems"
– Gaunitz

Even so, one concept, even a framework, can only go so far. In 2014, Samsom argued that one cannot create a "grand design" at a managerial level, but has to create a system wherein the profession (highlighting both doctors and nurses) can operate (Läkartidningen, 2014). On a similar track, Lindblad highlighted its usability as a "shared language, which works without us having to hang a lean-certificate on the wall".

The demand for the concept did not stop at SLL. In 2013, following a trip to Boston, where the management of Västra Götalandsregionen (VGR) attended lectures by Porter, same as SLL, BCG gained two new contracts. One in VGR and one in Uppsala (Westin, 2015). "Proficient marketing" one interviewee remarked. Associate hospital director of Sahlgrenska, Lars Grip, explained the rationale, "BCG was the only company that had the competency and could help us get started" (Svensson, 2013). Notably, there is now a curriculum on the concept at Harvard Business School, run by Porter, which "not only builds a cadre of people trained in new health care delivery thinking, but can also serve as a platform for other efforts by universities to contribute to local or national health care reform" (HBS, 2015).

Even though Sahlgrenska, in particular, have had a number of initiatives to trial and introduce the concept[24], Lindblad of VGR was clear that it was not being implemented in full; neither as a reimbursement model nor as an organizational model. Rather, they have opted for using and contributing to the ICHOM outcome standard sets, now listed as a "Strategic partner" of the organization[25], applying the quality measurement aspect of the concept, whilst seemingly letting KS & SLL take the lead.

[24] In part, by reportedly simulating its appliance as a reimbursement model within VGR (anonymous)
[25] Meanwhile, Uppsala Akademiska are listed as a "Bronze partner"

"[We await with] fear mixed wonder, and look on from afar. Seeing how far one can get, and how operational one can become."

– Lindblad

Strikingly, following a fierce, and seemingly intensifying debate in the media, also across political parties, it now seems as if the organizations applying the concept are beginning to use other terminology to say more or less the same thing, at least in the public discourse. KS, as noted above, talk about "Patient first", and VGR of "Care creating value" (Vård som skapar värde), rather than value based healthcare. Spring 2017, news broke, following a string of highly critical pieces on the concept and especially BCG's involvement in KS, stating that the consultancy had lost their project at the hospital, and that Uggla had been "wingclipped"; losing his operational responsibilities, due to his former ties to the consultancy (DN, 2017). However, when speaking with members of the management team, visibly distraught, they said the shifting role was old news, and that the need for BCG was over, as the organization was becoming increasingly self-sufficient. Remarkably, no shift in the application of the concept was even hinted at.

"I think it will end up with a Swedified version. […] It is not a Swedish way to build reimbursement systems"

– Lindblad

On a national level, the concept was used as a key enabler to increased choice of care, during the Alliance led government, as previously noted. Following the shift in government to the left block, in 2014, who are staunch opponents of choice of care, and vocal critics of the work within SLL (e.g. DN, 2016), the new healthcare minister, Gabriel Wikström, cancelled renewed state funding to the development of Sveus in 2015 (Westin, 2016), the "enabler for value-based steering". The reason stated was that the counties' R&D work should be paid for by themselves. The new government are now seeking to device a reimbursement model of their own (Westin, 2016). Even so, the platform is still under development.

Meanwhile, looking abroad, it seems as if BCG's vision of Sweden being world leaders in the concept is inching towards being realized. The Danish regions[26] did a feasibility study with Ivbar in 2015, leading to a coordinated national program for "Advanced Performance Monitoring", expected to start in 2017 (Ivbar, 2017b). Further afar, GHP have won contracts in the United Arab Emirates, where "the first couple of years we are only judged on the quality outcomes", according to Daniel Öhman, CEO, GHP (Dagens Medicin, 2016). New members of the management team are the former CEO of Sahlgrenska, Barbro Fridén, who was key to introducing the concept at VGR (Lindblad, Anonymous), and the former CFO of KS, as well as AstraZeneca, the pharmaceutical company, Susanne Ljungkvist.

[26] Akin to counties

Internationally, Deerberg-Wittram, BCG's top man within ICHOM, is now a member of OECD's "high level reflection group on health statistics", and ICHOM's standard sets for health care outcomes are now in process of being implemented under the acronym PARIS[27] (Wohlin).

The question is what will happen to the US, likely the largest healthcare market in the world, with escalating healthcare costs, now reaching nearly 17% of GDP (OECD, 2017), and in desperate need of reshaping their healthcare system.

[27] Cf PISA for schools

DISCUSSION

THE CREATION OF A MANAGEMENT FASHION

We have now borne witness to how the concept traveled from its origins, or should one say resurgence, and definition at Harvard by Porter and Teisberg, and subsequent coupling with the work of Kaplan, as a strategy to tackle the rising costs of healthcare, especially in the US, iterating on the DRG system; to how it found fertile soil in Sweden; and a golden opportunity within SLL at Karolinska University Hospital; was operationalized; and subsequently met with a great deal of resistance; yet, now seems here to stay, on track to spread internationally, not least through ICHOM's definitions being adopted by the OECD.

The rest of this paper seeks to elucidate the what, how, and why the concept was translated in a Swedish context, and then come to an end with concluding remarks and a discussion of the potential implications. By and large the following chapter follows the same chronology as the research questions, and theoretical framework.

OF ACTORS AND ANTHILLS

From a theoretical perspective, one could argue that the introduction of the concept is a product of mimetic isomorphism, with actors looking for ways to improve, and imitating success stories, driven by an institutional entrepreneur, who framed rising healthcare costs as unsustainable, a form of exogenous shock, to invoke a sense of urgency to drive the change. This researcher however, would argue that although certainly, there are some elements of this, the answer in its totality is not that simple.

Although the promotion of the concept in Sweden has clearly been spearheaded by Larsson at BCG, who are customary allies of Porter, the spread and adoption have not been the work of a sole actor. Rather, the results clearly show that this is the product of several, albeit few, likely due to the size of the Swedish healthcare sector, largely independent actors, acting together – which gives credence to the metaphor of emerging institutions as anthills by Czarniawska.

> *"My claim is that allowing the narrative of institutional entrepreneurship to be enriched with the image of an anthill may make it more realistic—not diminishing the heroism of ants, merely multiplying their number and character and stressing the connections."*
> *– Czarniawska, 2009*

The perhaps most telling event was when representatives from the industry, healthcare providers, academia, and public sector (primarily counties and government) in Sweden, met in 2009 in a seminar hosted by BCG. The meeting was led by Larsson, with two "foreign speakers", Michael Porter and Jens Deerberg-Wittram, the latter at this point listed as the COO of Schön Kliniken. In other words, ICHOM's founding trio. Other especially notable attendees were, Karin Johansson, serving as secretary of state under Göran Hägglund, the healthcare minister of the Alliance, later becoming a board member of Ivbar; Roger Molin (as an interviewee); and the former and current chairmen of the board: Per Båtelson, then CEO of GHP, and Anders Ekblom, then EVP of global drug development and later CEO of Astra Zeneca Sweden (Sweden's largest pharmaceutical company).

The emphasis in the presentation was on mutual gains for the stakeholder trinity; "payers & providers", "academia" and "industry"; as well as patients. The goal was to make a concerted effort

to build upon the world-class quality registries of Sweden to enable data-driven analysis within healthcare, with the espoused intent of giving the Swedish healthcare sector a five-year head start on its international peers and competitors. Although their motives were different, this gave the first impetus, and created an initial group of supporters – many who later became champions.

Thus, prompting the first level of analysis, presented in table 1 below, to attain an overview of the multiplicity of actors at work, and set the stage for the ensuing discussion. The actor net consists of the identified organizations, two of whom are bundled for the sake of brevity, due to their proximity of agendas and mutual opposition. Although typified and attributed an institutional logic, each actor has then been attributed an agenda; an idealized set of goals, or what Latour would call script; based upon the results of the study.

Table 1. Actors and agendas

NAME	TYPE	BASE	AGENDA
MODERATERNA VS SOCIALDEMOKRATERNA	Political parties	Power	• Patient choice - overarching steering principle (liberalism vs socialism) • Mandate on regional and national levels
PRIVATE HEALTH CARE PROVIDERS (E.G. CAPIO & GHP)	Business	Profit	• Opportunities for competition • Legitimating existence
IVBAR	Business	Profit	• Develop new analysis tools • Internationalization of Swedish health care
PORTER & KAPLAN	Academia	Influence	• Promote ideas/gain influence • Positive case stories – stepping stone to the US
BCG	Business	Profit	• Competitive advantage • Generating market demand • Long and profitable contracts • Customer branding • Employer branding (including towards its existing employees)
SKL	Public procurer	Cost	• Operational improvement • Cost efficiency
SLL	Public procurer	Cost	• Cost control • Queues in health care • Prestige project • Political battleground (M vs S)
KAROLINSKA UNIVERSITY HOSPITAL	Public provider	Mixed	• Cultural/organizational change • Power leverage vs. the profession • Improve staff turnover - particularly among nurses • Operational improvement • Stable profitability • Fulfil its academic mission • Employer branding
LÄKARFÖRENINGEN VS VÅRDFÖRBUNDET	Unions/Professional associations	Power	• Status and role of profession • Security of employment

COLLECTIVE TRANSLATION

"An artefact's reciprocation (the ways in which it can be used) always exceeds the designer's projection"

– Scarry, 1985

The original setup was to expand upon the quality registries, and (albeit tacitly) the initiatives in "God Vård", to provide data driven analysis, based upon outcomes measurement. The IT platform was set up in a three-tiered approach: ICHOM provides the definitions/standard sets, to allow for comparability of data; Sveus provides the national benchmarking/business intelligence platform, in cooperation with the counties; and local healthcare providers collect the data, and provide both expertise and legitimacy, as members of the profession, to aid the creation of the definitions, of whom Uppsala Akademiska, Sahlgrenska and Karolinska are now the pioneers.

As the concept was contextualized in Stockholm, other interests soon came into play. The first one, was being embroiled in the Alliance's push for choice of care; as part of a larger move to introduce competition in various areas of the public sector to increase efficiency, and reduce waiting times; which has become subject to a rather long-running and particularly fierce debate, on both national and regional levels, on profits in companies tied to the public sector[28] (state welfare), although so far only in regards to schools and healthcare. The second one, was becoming the linchpin of a wide ranging organizational reform at Karolinska.

The multiplicity of actors subjected the concept to, what this researcher would call, a form of collective translation; a term highlighting the multilateral, as opposed to bilateral, cooperation/actions that the array of actors entail, and its capacity to be both distributed, and concentrated, yet not necessarily parallel; an anthill in action. Tying into this, many of the interviewees saw the core concept as obvious; a certainty. Yet, multiple meanings of the concept existed among the actors, as well as to some extent even within the same organization. The latter of which was likely engendered by the close to viral spread, as opposed to a single emanating source, as seen in e.g. the intro at Karolinska through the semi-autonomous clinics, as well as the work of Wohlin et al.

An implication of this is that creating a fashion may mean losing control – just see Toyota and Lean – something that becomes especially poignant when a concept is strongly linked to one's brand. The contextualization of an idea is in translation theory argued to have an intrinsically heterogenizing effect (Czarniawska & Sevón, 1996). That said, the process of translation, can visibly not only entail differences in application, but also the discovery or application of new meaning, an adaptation of the concept to one's own purposes. This also ties into the actor net, whereby some actors may start out as amplifiers, or even opponents, but then realize how they can gain from tapping into the fashion, by creating their own variant or otherwise aligning with it. Overall, something which provides a rather interesting take on the concept of emergent strategy (cf. Mintzberg & Waters, 1985), or that of muddling through (cf. Lindblom, 1959).

[28] Swedish: "Vinster i välfärden"

"The power behind the travel does not stem from one single, powerful source, but is created from the richness of the interpretations the idea triggers in each actor within a network"
– Andersen & Røvik, 2015

ORGANIZATIONAL RESPONSES

Thus, as the concept met with reality, reaching its intended main users, what were the organizational responses, as part of its collective translation? Or as Røvik put it (2011), the idea-handling processes incurred apart from pure adoption or rejection?

DECOUPLING

Naturally, the idea was not adopted in every aspect. As Sahlin-Andersson said, "When the old model and the new ideals seemed contradictory, they decoupled old and new models by applying them to different situations" (1996). Although espoused as potentially all-encompassing, there have been multiple occurrences where the concept has not been viewed as sufficient.

The first example are the "multi-sick". Patients suffering from multiple, and often complex conditions (or comorbidities if you will), where having both clearly delimited patient flows based upon specific conditions and bundled payments for the full care cycle have been subject to criticism (Fernler et al., 2014). The latter, by and large due to the difficulty involved in allocating funds among all the actors involved. Instead, for these patients, the concept is now used for quality control, as well as to provide an additional source of information during budget negotiations (Anonymous).

Secondly, one interviewee, in reference to Sahlgrenska and VGR, expressed it as "it is the philosophical thought that we have adopted". A situation, wherein Uppsala Akademiska, and Sahlgrenska, although initially among the early adopters, have opted for letting KS lead the way in operationalizing the concept. However, they are simultaneously building some of the prerequisites for implementing it themselves at a later date.

REVERSE DECOUPLING

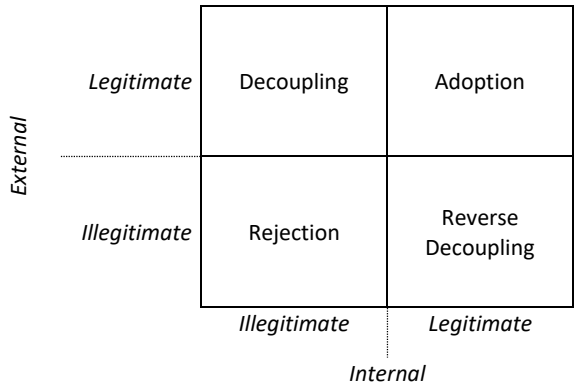
The explanation puts the traditional description of decoupling and rationalized myths on its head. I.e. what Røvik (2011) would term a form of isolation-process, whereby an idea is formally adopted, but not implemented; "decoupled from organizational practices".

In its contextualization, and during the process of adoption, following a media backlash, it now seems as if the umbrella concept has taken the blame. Not only do VGR and Karolinska no longer headline with Value based health-care when describing their practices in their public information, but one of the authors themselves now spoke of professional pride rather than economics as the main driving force for change, when applying outcomes measurement (Larsson), which stands in stark contrast to previous descriptions.

In other words, the concept had become seen as the rational among the interviewees, "it is obvious", whilst also having become somewhat tainted in the public discourse, seemingly leading them to change their public communication, without changing their practices. In other words, instead of espousing to follow a pervading rationalized myth to gain legitimacy but decoupling it from the operations to preserve efficiency (in the matrix below: external legitimate, internal illegitimate), they are operationalizing the rationalized myth to gain efficiency but espousing not to follow it-which-must-not-be-named to preserve legitimacy (external illegitimate, internal legitimate). In effect, they

are still decoupling espoused and operationalized strategy, but the mechanism is functioning in reverse[29].

Table 2. Decoupling & Reverse Decoupling, Idealized



HARMONIZATION

Not only was the concept applied, but in its operationalization, it was also reaching further than perhaps originally intended, and what was contingent for pursuing outcomes measurement in the first place, which relates back to the statement by Scarry. As one element was put in place, mainly IT and accounting infrastructure, "it was logical" (Anonymous) to design other elements of the organization thereafter. In other words, a harmonization of organizational elements.

However, the harmonization did not only affect the internal organization, but also external organization contingent upon it. One cascade effect was "creating a home for the medical specialties" (Samsom). As Karolinska is a university hospital, themes, based upon patient flows, as concentrations of care, also affect the integration of research and education. Although the network access and heightened level of data were intended as selling points for both education and research, the new organization also results in an inability for them to pursue their beaten paths, as noted by Gaunitz. In other words, the changes to the clinical structure at the hospital necessitate either changing the interfaces between the hospital and university, or implementing a similar organization within the university, and by extension potentially within the profession itself.

ENVELOPMENT

Although one can posit the concept as the driver of an extended change beyond its original requisites (what was contingent for its operationalization), an alternative perspective, is to see it as a form of collecting banner. A banner enveloping other ideas; ideas whose contingent actions together create the guise of an extended change.

"Value-based healthcare became the solution to everything"
– Anonymous

[29] Notably, similar occurrences have been described by both Fernler (SOURCE) and Røvik (SOURCE).

Many of the ideas employed are far from new. Samsom has been spoken of by numerous interviewees as a "true believer" in the concept. This should not come as a surprise, given that the IPUs/team structure, publication of (some degree of) outcomes data, and cooperation with patients, had all been employed in the Netherlands. Only at the time, they had seemingly yet to be categorized as value-based healthcare.

"The flow principle on a patient level is here to stay"
– Båtelson

At Karolinska, the transformation was from Lean as a governing principle, with the concept as its "concretization", to a "Value based healthcare improvement system", with Lean as a "toolbox" (Ringman Uggla). This, despite, or perhaps even engendered by, the two ideas' base level similarity, even in core philosophy, as methods for continuous improvement. "Value-based healthcare became the answer to everything" (Anonymous). As Lindblad noted, "It is not only that you change, but you trash-talk the old. (…) It is like religions". In other words, as one idea gained supremacy, the other was rather spoken of as an operational measure supporting it, as opposed to a competing management principle. This can visibly also occur during the introduction of an idea, which hints at this potentially being a mechanism for competing ideas overall. It also alludes to the virus metaphor by Røvik, providing further detail to what he calls dormancy. I.e. by being originally posited as a supporting idea, the apparent threat level was reduced, only to later become the dominating idea.

From the flip-side, this implies that although the new idea became dominant, that which they viewed as a must have – the patient flows – which had been part of the previous ruling idea, seemingly became solidified.

POWER AND INSTRUMENTALITY

If the concept functioned as a collecting banner, then by extension, the concept should be seen as part of the transformation, its vehicle, as opposed to its driver. In other words, an instrument for change – which begs the questions of how, and why it was used; how did it function, and to what end?

THE ONUS OF LEGITIMACY

Private health care providers (and to a lesser extent procurers, in the form of insurance providers) in Sweden have long had the onus of proving their legitimacy, their reason for being, given the historical reliance on public providers. In other words, institutionalized organizations (Meyer & Rowan, 1977), whose organizational identities face fierce scrutiny. The Swedish discourse often speaks of "profits in welfare", and how private ownership and the profit interest of business, incentivizes cost-savings above quality. Outcomes measurement, previously in the form of "Öppna jämförelser", and now in the form of the concept, thus provided an opportunity to benchmark their services versus the public sector, to give credence to their operations, and enable them to be evaluated on more or less equal terms as the public providers.

STANDARDIZATION AND PARTIAL ORGANIZING AS A POWER TOOL

Even though outcomes measurement, in terms of power, seemingly started out as a way to provide legitimacy in the private sector, the concept's adoption at Karolinska rather seemed driven by an

urge to gain a tool for driving change within the organization, as discussed in "the golden opportunity".

"It will force the doctoral profession to go 'from god to guide'"
– Anonymous

Quality control in healthcare is nothing new, but by introducing quality measurements set by the patients, in addition to those already set by the profession, which are largely processual in nature, doctors lose their status as sole judge, jury and executioner (Anonymous). Something that is engendered by elevating the involvement and standing of the nurses, which was a goal in itself.

Furthermore, the intention is to force cooperation between providers across organizational boundaries (Anonymous), i.e. by aligning their goals around patient outcomes, which ties into the aspirations of creating "networked healthcare" (arguably a form of partial organizing, cf. Ahrne & Brunsson, 2011). Coupling outcomes measurement with case-mix adjustment and an increased predictive ability is also intended to enable benchmark through establishing comparability of service, for both public and private providers, through a shared definition of how to measure quality, adjusted for potential differences in patient composition. In effect, lessening the previous interpretive power resting on professional belonging and status, in favor of data-driven analysis (Anonymous).

The definition of quality changes not only in terms of what is a good outcome, but also a good process. By introducing best practices, standardized operating procedures (SOPs), with the aim of "minimizing variation in quality" by "minimizing variations in practice", the standardization affects not only the goals, but also the operations. The likely aim is that it should pervade the organizational culture, and change its very discourse, thus acting as an instrumental measure, a power tool, through defining the rational (cf. Flyvjbjerg, 1998); that which the organization and its members are measured and measure themselves by. Deviation becomes difficult, as new sources of legitimacy are created, and behavior institutionalized – thus creating the iron cage of the organization.

"The common belief in and adherence to the importance of the definition of what activities are all about holds the field together"
– Bourdieu, 1977 (cited in Sahlin-Andersson, 1996)

The flip side of standardization of practices is probably best illustrated using an idealized normal distribution curve of talent. In effect, SOPs and a defined set of processes are typically good for the average practitioner, they are the ones who the practices are set for, no complaints there. The lower-end on the other hand will face increased difficulty, as they are forced to up their game or risk being exposed within the organization. Reversely, the higher-end, the very best, will also face increased difficulty, as strict guidelines may now be forced upon them, limiting their innovative capacity – with a not seldom stated of view of best practices as 'Why should I follow what was best a year ago?'. One interviewee expressed it as, "Standardization of behavior will always lead to stagnation" (Anonymous). The counterpoint to this by design comes back to the outcomes measurement, which the same interviewee argued was qualitative as means to "open up for the profession".

Although one could argue that competence development, akin to coordination through education (cf. Mintzberg, 1980) might have been a more enabling plan of action, one interviewee noted that it

came down to two elements, in part within Karolinska, but more markedly so within SLL: uncertainty, or more specifically trust, as well as the need for follow-up and quality control, to enable creative destruction (cf. Shumpeter, 2008).

IDEAS AS REPRESENTATIONS OF AUTHORITY

As ideas act as tools for legitimacy, and carriers of meaning, a secondary function is that they can visibly also become artefacts in the battle for power. Revisiting the discourse around lean and the concept, and how ideas can function as collecting banners through a process of envelopment; these are ideas which were tightly bound to their champions in the management echelon, whose supremacy closely followed each other. This even went as far as to in multiple events limit the vocabulary used within the organization, when certain words were connoted with the competing idea.

In other words, ideas can not only be used as power tools to enact change, but on a micro-level arguably also function as representations of authority; the ideas themselves becoming an extension of their chief proponents, which is likely engendered when the competing ideas are largely umbrella terms. One possible consequence of this is a situation wherein if someone wants to challenge the efficacy of either an idea or its proponent, one must also challenge the other, which is powerful yet brittle, and can have far reaching consequences for decision-making within an organization.

LOST IN TRANSLATION

As established, the concept in itself was largely beside the point. Ultimately, any change is about people, and ways of working, both individually and collectively. From a power perspective, the view of the concept as a power tool, a way to enact change within, as well as between organizations has become apparent. That said, one should not forget its function as a communicative device, which, in part, has arguably reenergized a longer running change process, or perhaps, from a highly critical perspective, provided an alibi for the previously slow to enact changes.

Having reviewed the what, how and why, one question remains: why did the members of the organization respond the way they did? What was it that failed in the concept's introduction within Karolinska, and why? The answer it seems, lies less in strategy, and more in execution[30].

KNOWLEDGE BASES AND LEVELS OF DISCOURSE, REVISITED

Within the organization, there seems to have been an overarching disregard of the rigors of the large scale technical implementation necessary to support the new concept. One potential explanatory factor, apart from a tight schedule, is that a profession may disregard that which is not tied to their own knowledge base. Either due to ignorance, or due to seeing their own dealings, that tied to their own organizational logic, as having supreme importance – as was witnessed in the case of the general rehearsal, and the failure to setup the contact sheets, resulting in utter chaos, and ensuing criticism of the technology itself.

[30] It is always easy to point out issues in hindsight, but these are variables which should be examined nonetheless, and, as one interviewee commented, "There have been far too few thoughts about" (Anonymous).

Another element was the translation work demanded to create a wide understanding and acceptance within the organization. The question of how to translate structural changes into something tangible on an operational level, because, why should the operating core care about the overarching philosophy, or grand design? How does one create the sense that the new organization and management tools will enable a better long term steering, as opposed to being another reorganization without much to back it up?

"It is new names. We call clinics for a flow instead, our clinic is divided into three different flows, but what we do with our patients will be largely the same. […] The risk is that all of us who have been very enthusiastic for the thematic organization may become disillusioned, and perhaps lose our ardor"

– Holm, Professor of surgery, KS (Shapiro, 2016)

Given that there is an organization in which there are multiple levels of discourse, as well as differing knowledge bases, how does one translate a concept so that feels real, tangible, graspable, understandable? Which begs the thought that perhaps translation is a necessity in any attempts at organizing, involving hierarchy and differing knowledge bases.

IDENTITY CONSTRUCTION AND COGNITIVE DISSONANCE

As per its social constructivist perspective, translation theory often speaks of identity construction, whereby when introducing new ideas, "new" logics are also drawn upon (Sahlin-Andersson, 1996). The identity of the target is thus reshaped, as they through adopting the new logics, enter new organizational fields, or rather, are influenced by a different field. In other words, "the changes in identity precede and form the basis for further changes, forming as adaptions to the new organizational field" (ibid.), which arguably bears a lot of similarity to the notions above.

This process can in turn lead to institutional confusion (cf. Brunsson, 1994), a form of cognitive dissonance, which Sahlin-Andersson argued can lead to the formation of new local identities as a way of resisting, through raising cultural barriers (Cf. Kanter, 1993). Identities whose new outlines can even be based upon previously non-defined criteria. Arguably visible in the way that the doctors might have felt at a loss in terms of professional status and identity, following the increased codification of their work. Thus, providing another perspective on the response from the professions, and the inertia of change, which also speaks of why the umbrella term can, and partly has taken the blame, perhaps as a way to secure group integrity, despite continued implementation.

In other words, it may be possible, to stray too far from the existing norm, the perception of what is rational, with eyes fixed on achieving far reaching change. This presents a challenge for the translators, who must tread carefully to not fully break with the existing identity, the local sensemaking apparatus, in the process of contextualizing an idea (i.e. localizing content), or, perhaps more radically, in its local construction. Which seems to be quite telling of what happened.

ALL NEW, ALL AT ONCE, REVISITED

The change process at Karolinska entailed replacing all managers in the organization (including rehiring and reallocating about 60 % of them), in seven weeks (Anonymous; Dagens Medicin, 2016c). The efficiency of which was spoken of as a point of pride by its proponents (Anonymous). This seemingly did not stop on a middle-management level, but also affected the upper echelon, which

has gradually been replaced by "like-minded individuals" (Anonymous), where Michael Fors was described as the last of the old guard.

By and large, this seems like a classic approach to how if one cannot change the culture quickly enough, one changes the people. Whilst that may be true in part, keeping in mind that most of the managers were re-staffed, albeit with some potential reshuffling, this was also likely a way to circumvent the Swedish Employee Protection Act[31], whereby they could now freely ensure performance and/or conformity. It should also be noted that the speed and reach of the changes are by and large set with the goal of completion by 2018; which is the year of the upcoming, highly contentious, election. 2018 is also the year when a new reimbursement model will come into effect for Karolinska – the question is if it will be one based upon bundled payments and patient outcomes.

"A terror-process in the eyes of the doctors"
– Anonymous

The change process did not go home well with the doctors. One interviewee spoke of the mood within the organization as borderline "rebellious". Reviewing the employee surveys, Karolinska and SLL are now rated as the least favoured employer among all public healthcare providers in Sweden. Notably, following the brunt of the changes, by 2016 the question on "confidence in the management team" was removed from the official employee survey; a dire situation indeed. Following this, Karolinska's medical association[32] made a survey of their own, targeting the doctors with 1394 respondents, which displayed a level of confidence in the CEO of 3 %, with an average rating of 22/100 (KSF, 2017).

THE IMPORTANCE OF PEOPLE

Not only did the change effort break with the reigning organizational logic, but its chief proponents were seemingly seen as representatives of something else. An expressed benefit of hiring a Dutch CEO, Samsom, was that he was an outsider, as he had a clean slate with no existing connections nor dependencies, but being an outsider is a two-edged sword. Having a "foreigner" in charge of a Swedish public institutions was reported as seen as something strange within the organization (Anonymous). This was engendered by Mikael Fors, former deputy CEO, hiring an ex-consultant, Ringman Uggla, to act as COO, and right hand of the CEO in the change process (Anonymous). A person who was not only seen as an outsider by virtue of his professional identity (education aside), but also as carrying a potential conflict of interest, coming directly from BCG.

Perhaps reinforced by the sense of otherhood, the two were by multiple accounts described as a duo, supported by their "change partners", leading a top-down change effort, where the HR and communication strategy largely came as an afterthought (Anonymous). As one interviewee remarked, "Everything has proceeded at such extreme speeds" (Anonymous), leading to a "total uncertainty" within the organization – not least following the management change-over. This stood in stark contrast to the former CEO, who employed a much more consensus based and informal leadership, whom his critics argued bordered on non-present. The flip-side is that likeability is not

[31] Swedish: LAS – Lag om anställningsskydd.
A law largely employing a last in first out principle.
[32] Swedish: Karolinska Universitetssjukhusets Läkarförening

everything, and this might have provided the force necessary to enact change within the organization.

THE ISSUE OF SELF-DETERMINATION

That said, even though the change effort may or may not have had the capacity to affect the local sensemaking apparatus, it is still socially constructed, and thus, also susceptible to the perception of others. Have then a large public project; in which there is a great deal of interest from the public and media; which is engendered by significant political interest, as politicians govern the steering, and as such are held liable, thus becoming part of their pursuit of power; and public scrutiny becomes neigh unavoidable.

Even though the people within the organization may initially have been convinced that what they were doing was right and well, it would likely take a fair amount of fortitude to remain stalwart in the face of continuous external clamor. A situation which was likely engendered by the internal communication admittedly not the being forte of the change effort. Thus, not only facing an antagonistic discourse externally, but also lacking a strong positive discourse internally, it is no wonder that questions were raised as to the efficacy – the legitimacy – of the concept, and its proponents. A perspective, which in other words, further highlights a dynamic perspective on the mechanisms of decoupling.

Furthermore, bearing in mind the frequent leaks, articles by the unions, and other stories in the media, the barrier between the external and internal discourses was visibly permeable – which should imply an intensification of the dynamic whereby one influences the other.

One potential explanatory factor of this reluctance and/or inability of discourse management, is that management consultancies have historically been rather strict on acting without being seen. That said, as they are increasingly pursuing public projects, especially when it is within hotly contested areas (e.g. when targeting so called institutionalized organizations), the need for governing not only the internal, but also the public discourse becomes readily apparent. A need strengthened by the journalist corps largely having a different knowledge base, leading to management ideas rarely being translated in the media. In other words, straying on the normative, presenting a case for PR in management consulting, as public change efforts entail public discourse.

CONCLUSION

This study is a telling example of how a management idea, turned fashion, can function as a powerful instrument creating sustainable competitive advantage in the business of ideas, among the merchants of meaning. From a strategy perspective, one can view the contextualization of the concept in Sweden as a high-odds bet. A bet involving a lot of firsts, which if successful, could have far reaching consequences stemming from a single move – in part, due to the high level of systems concentration and trust present in the Swedish public sector.

On a basic level, outcomes measurement demands new capabilities of the organizations that seek to engage in it, as well as the network of dependent organizations around them. To support this, ICHOM, a standardizing body which has quickly gained far-reaching influence, was seemingly created as the ultimate tool of mimetic isomorphism – facilitating the creation and dissemination of a standardized, ready-to-use set of definitions of patient outcomes. Although the concept is not intrinsically novel or unique, the consultancy who are perceived as its original proponents have a lot to gain from the demand for the organizational expertise required for its implementation. Especially if they come armed with a successful flagship case, and a commanding influence over the steering measures (although formally separate).

So, does this imply that the key clients, SLL, and the management team at NKS, were simply pawns, providing the university hospital of the capital as a test-bed for a hitherto unproven concept, as part of an international business strategy? The evidence presented in this study suggests, not quite. The concept rather seemingly became so strong a fashion due to its instrumental capacity – being utilized by several actors, to pursue forceful change to their own ends, as summarized in table 1, perhaps no matter the concept itself.

For all their intents and purposes, fashions are pluralistic by definition – which also implies that creating one may mean losing control. In other words, revisiting Czarniawska's metaphor of emerging institutions as anthills, although one can set the core design features, their interpretation and usage may differ.

The functions of the concept examined in this study were numerous: it provided a tool for the standardization and benchmarking of the outcomes and costs of healthcare, which *outwardly* created legitimacy for organizations operating in an institutionalized environment; enabled competition *between* them, a form of market creation, as part of a larger political struggle to allow privately owned health care providers; drove change *within* them, and the professions tied to them; and finally, on a *micro*-level, functioned as a representation of the authority of its proponents.

Yet, despite the apparent strengths of the concept; with its capacity to define the legitimate, the rational; it seems as if the execution of its implementation was not sufficient, at least not for a smooth ride. The change process was led in a top-down manner, on a tight schedule, without clear buy-in from the organization at large, and an implementation seemingly largely outsourced to consultants. Naturally, this engendered the difficulties of a seemingly already underestimated translation process. Subsequently, in trying to affect the sensemaking apparatus of a highly institutionalized organization – in the local identity construction – the change effort failed, either due to unwillingness or inability, to manage both the internal and the external discourses, tainting the

perceived value of the concept. The latter of which has led to a reverse decoupling, and an intensification of the internal uncertainty.

From a wider perspective, the continuous efforts for increased cost control within Swedish healthcare, likely in tandem with the overarching political conflict, have now led to the creation of a government appointed "delegation of trust"[33]. In other words, a case in point for the conflicts surrounding the process of institutionalization, and the limits and criteria of professional identity met in the micro-struggles of institutional confusion.

Thus, having traced the travel of a concept, and the first steps of the creation of a (potential) management fashion, this paper concludes.

MAIN CONTRIBUTIONS

This study has charted how Value based health-care delivery has been translated in a Swedish context. Providing a metaphorical map, to elucidate a contemporary (in the fullest sense of the word) societal phenomenon, which carries with it far-reaching implications, and provide an example of contextualization in practice, and "what the process of institutionalization looks like" in its early stages (Ahrne et al., 2007). A map, which intentionally leaves ample room for further analysis.

Large scale projects, and especially management fashions, often seem steered by something akin to an invisible hand. This study counters that to some regard by design and interview material – not only charting the chain of events (cf. Czarniawska, 2004), but also, offering a peek into the inner workings of one such phenomenon – charting the variety of actors, agendas, and actions central to its contextualization. The result of which is, per the member checks, supposedly both novel in perspective and accurate in description.

Lacking the theoretical tools, within the traditional school, as well as within the sociology of translation, to adequately answer the research question, a more dynamic perspective was employed. In essence, by (re)introducing power, and sensemaking as the mechanism whereby the rational is defined, to form a provisional framework for examining the phenomenon.

This study thus contributes a telling case exemplifying and developing the sociology of translation; of the anthill metaphor (cf. Czarniawska, 2009), the diverse instrumentality of management ideas and fashions (cf. Røvik, 2011, 2016), the issues faced in the translation work required in their contextualization, not least in the management of both internal and external discourses, in efforts to affect the local sensemaking apparatus of an organization, as well as of the collaborators of the co-production, and co-consumption of management ideas and how they operate (as called for by Røvik, 2011). In doing so, it has also examined the instrumental capacity of standards, and how they can serve to define the rational to drive a variety of changes; providing an operative take on the so called "soft laws" often examined within the Scandinavian school. An example, which can furthermore serve to develop theories of the process and drivers of institutionalization.

[33] Swedish: "Tillitsdelegation"

Lastly, this study provides an example of an idea that has been/is being operationalized, and not only hypocritically so. Based on that, in conversation with the "traditional" theory, inspired by Røvik's tentative model which diversified the taxonomy of organizational responses to management ideas (2011), three organizational responses, which are all various forms of adoption, are outlined: reverse decoupling, harmonization and envelopment. The second of which is arguably the polar opposite of decoupling.

SELF-CRITICISM

In hindsight, one can question the case itself. Firstly, is this not a highly a-typical case, compared to most organizational changes? A "perfect storm", if you will, with considerable interaction effects? Secondly, is the perspective not (unavoidably) myopic? Perhaps, what is being studied here is a sign of something greater? A reflection of the paradigm that we are in, but might have trouble pinpointing – an overarching management fashion? Given the emphasis on the ultra-modern, and the rise of big-data, data-driven analysis etc., although bordering on taboo, is not what is being witnessed here a form of Neo-Taylorism? An idol to which we worship, in the hopes of salvation. Something which becomes all the more poignant, especially given how many of the issues faced by public health care providers have been, perhaps controversially, expressed as rather basic in nature: e.g. lacking in efficiency of production compared to private providers, and having highly nascent organizations rooted in professional silos.

Be that as it may, the variety and stakes of the agendas at play, arguably make it all the more interesting; especially when coupled with the instrumental capacity of a management idea or fashion, whose legitimizing effect should naturally be strengthened when it is flowing with the zeitgeist.

Speaking of instrumentality, examining the method, the data-collection might have been subject to self-beneficial bias on behalf of the interviewees, as many of the them have either had, or have a significant role in the chain of events described, or have some form of ties to the actors involved. The information given may also have been knowingly biased, which may result in this study functioning as a tool for their purposes, whatever they may be. Hopefully this was mitigated by triangulating the views of multiple stakeholders, as well as documents and media reports, whilst continuously questioning what is plausible or not. Notably, there is some information which was given strictly off the record from the interviewees (which was conditional for their acceptance), which, although it would have provided additional nuance, still served to aid the heading of the research and the analysis made.

Another potential bias, is that of perspective, on behalf of both interviewer and interviewees. Both are rooted in the management perspective, which might entail a rather different view of the change effort at Karolinska than that of the employees in the operative core. Somewhat simplified, to mitigate this, to dig deeper into the internal change process and ascertain the view of the employees, Alasaly's interviews contributed the views of three division heads; the media coverage, that of disgruntled employees and by and large the unions; and the interview with the CEO of ICQ, who design the employee surveys, that of the employees in the organization in its totality.

Other deficiencies are that no representatives from the pharmaceutical companies have been interviewed; nor the finances studied, which may have been an underlying factor, especially in a situation of scarcity – although the financial director of SLL gave no such indication.

That said, the perhaps most overarching issue, which also carries with it great potential, is that the chain of events does not end here.

FURTHER RESEARCH

There is still a need to go back to the original strategy formulation (cf. NKS-förvaltningen, 2009), and the earliest conversations within SLL, with the former set of directors, and within KS, especially with the division heads who were part of its introduction. This could contribute to a greater understanding of the lattice-work, and seemingly close to dialectical relationship of influential ideas (of which envelopment is a potential mechanism). Furthermore, the subject matter is an ongoing event, which will likely demand revisiting.

There is also opportunity for comparative studies. Not only of the public providers of Sahlgrenska, and Uppsala university hospital, but also of the private providers. Capio, and GHP are prime examples, especially if one wants to study the spin-off of the concept's contextualization in Sweden, in how it is now seemingly reaching wider dissemination and becoming part of Swedish exports. Another striking question mark is how ICHOM's standard sets are seemingly coming to be assumed by the OECD, under the acronym PARIS.

The theoretical framework employed in this study could be developed further. One possible development is further integration of the literature on change management, as it could deepen the understanding of the process of translation, in the contextualization of ideas, as well as their instrumental capacity. Another thought that could use further development, was how one can view management ideas as narrative tools, and what its implications are for the role of the merchants of meaning.

Finally, the automatization and digitization of healthcare, or really, any professional industry, especially with the rise of IOT, is a phenomenon which could likely also be quite telling of the limits and criteria of professional identity, in attempts at structuration, standardization, and/or automation.

APPENDIX

APPENDIX 1. LIST OF INTERVIEWEES

NAME	ROLE	ORGANIZATION	DATE
PER BÅTELSON	1. Chairman 2. fmr Chairman 3. Initiatior/fmr CEO	1. IVBAR 2. Karolinska University Hospital 3. Capio & Global Health Partner	7/3/2017 & 1/6/2017
ANONYMOUS	Project leader	IT Consultancy, Karolinska University Hospital	22/3/2017
PER SHAPIRO	Investigative reporter	Swedish Radio (SR)	28/3/2017 & 18/4/2017
JONAS WOHLIN	CEO	IVBAR	18/4/2017
ANDREAS RINGMAN UGGLA	1. COO (changing) 2. fmr Principal	1. Karolinska University Hospital 2. Boston Consulting Group	19/4/2017
MARIE LJUNGBERG SCHÖTT	"Sjukvårdslandstingsråd" (board of directors - healthcare focus)	Stockholm County, Moderate party	20/4/2017
HENRIK GAUNITZ	1. Financial director/ deputy CEO 2. Board member	1. LISAB 2. Karolinska University Hospital	26/4/2017
MELVIN SAMSOM	CEO	Karolinska University Hospital	26/4/2017
RAGNAR LINDBLAD	1. Division head, Future Healthcare Processes 2. fmr Managing Director 3. fmr IT Director	1. Region Västra Götaland 2. B3IT Healthcare 3. Danderyds Sjukhus	27/4/2017
STEFAN LARSSON	1. Senior Partner & Managing Director 2. Board member & Founder	1. Boston Consulting Group 2. ICHOM	1/5/2017
ERIK WIKLUND	1. Head of advanced analytics 2. fmr Head of strategic analysis 3. fmr Business- and Operations development manager	1. IVBAR 2. Sahlgrenska University Hospital 3. Karolinska University Hospital	4/5/2017
HANNA EMAMI	CEO	IC Quality	12/6/2017

APPENDIX 2. LIST OF INTERVIEWEES – MOSA ALASALY

NAME	ROLE	ORGANIZATION	DATE
PATRIK ROSSI	Managing Director, Emergency Medicine Function	Karolinska University Hospital	13/3/2017
ÅSA DEDERING	Managing Director, Allied Health Professionals Function	Karolinska University Hospital	29/3/2017
DAVID KONRAD	Managing Director, Perioperative Medicine and Intensive Care Function	Karolinska University Hospital	26/4/2017

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