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## **Do Public and Private Health Care Centers Differ in the Way They Enable Their Employees to Influence the Management Control System?**

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**Abstract:** The following report aims to investigate similarities and differences between the management control system (MCS) of one public and one private health care center. By using Ahren and Chapmans' (2004) reinterpretation of Adler and Borys' (1995) notions of enabling and coercive control, the individual employee's ability to influence the MCS is explored. In order to capture the worker's experience, with its many nuances, a qualitative method was applied. The primary source of data consisted of 10 interviews, divided equally between the two health care centers. In line with previous research, converging movements were found in the MCS of the public and the private organizations. However, the empirical findings revealed that the individual employee in the private health care center was provided with greater capabilities to influence the MCS. In conclusion, the private health care center used enabling control to a greater extent.

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**Key Words:** Management Control Systems (MCS), New Public Management (NPM), enabling control, public, private, health care

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# 1. Introduction

## 1.1 Background

In 2009, free healthcare choice was introduced according to the act (2008:962) on System of choice (Sw: *Lag om valfrihetssystem, LOV*) (Capiro, 2018). This allows patients to choose freely amongst various providers of health care, which has increased the competition in the health care industry (Ekonomifakta, 2017). Consequently, a successful health care center must not only provide high quality services, but also strive for increased efficiency and meet financial targets. These elements are all included in Hood's description of the global paradigm New Public Management (NPM). The evolution of NPM can be described as a transition where citizens have become customers on a free market where they can buy public services, now marketed as products, in any of the public sectors' stores (Agevall, 2005). Since Sweden is one of the leading adopters of NPM (Hood, 1995), the impacts are clearly reflected in the increasingly competitive landscape in which health care centers operate today.

While the increased competitiveness stresses the importance of efficiency, it has been argued that too much weight has been put on production in quantitative terms. Hence, the question of whether or not the efficiency has increased at the expense of quality has been a highly debated question in the Swedish society (Malmgren & Augustin, 2013; Björgell, 2017). Previous research within the fields of leadership, lean production, sociology and technology (e.g. Gitell, 2009; Chaudry et al., 2006; Butler, 2008, Koning & Verver, 2006; Thatcher & Oliver, 2001; Bates, 2002) has aimed to explore the means to achieve the desired balance of efficiency and quality within the health care sector. Consequently, the role of management control systems (MCS) in the pursuit of this balance should also be of great interest.

Although many researchers have sought to understand the effect of NPM on MCS (e.g. Malmrose & O'Grady, 2017; Pettersen & Nyland, 2006; van der Kolk & Kaufmann, 2018 ) few have explored the effects from the perspective of the individual employee. More specifically, the extent to which public and private health care centers allow its employees to influence the MCS appears to be unexplored. Thus, the following report aims to add to the limited existing research which puts the role of the individual employee in focus.

As the evolution of NPM started in the 1980s, with the core idea of lessening or removing differences between the public and private sector, similarities are expected to be found in their MCS today. In order to examine this question further from the perspective of the individual, Adler and Borys' framework of enabling and coercive control will be applied to one public and private health care center. Amongst the vast field of various frameworks, there is a tendency to emphasize the need for improved efficiency while neglecting the value of flexibility to deal with inevitable contingencies in a complex work environment. In the light of this deficiency, Adler and Borys' framework may provide guidance in the pursuit of both efficiency and flexibility through the use of MCS (Ahren & Chapman, 2004). Finding this balance is of utmost importance, as a lack of flexibility may affect the quality in a health care center negatively (Karolinska Institutet, 2011).

## 1.2 Research Question

The aim of the thesis is to describe and analyze the MCS of a public and private health care center, in order to identify any similarities or differences in terms of enabling and coercive control. The research question to be examined is thus:

*How do the MCS of public and private health care centers coincide or differ, in terms of their use of enabling and coercive control?*

## 1.3 Delimitations

The following thesis has been delimited on three dimensions. Firstly, the comparison is exclusively conducted within the geographic area of the SLL. This county council was primarily chosen with regard to the feasibility constraint, as a comparative case study outside the area would impose practical issues for the authors who are based in Stockholm. Secondly, the study aims to describe and analyze similarities or differences in the MCS of the chosen public and private health care center without seeking to draw any conclusions on which MCS may be the most appropriate one. Hence, the second boundary is imposed by the strive for objectivity to increase the validity of the report. Thirdly, and perhaps most importantly, the concept of MCS must be clearly defined in order to conduct a focused and coherent study. Malmi & Brown (2008) emphasize the need for future research to be more explicit about the kinds of controls that is addressed. Thus, the study will only address the enabling and coercive

approaches to control, as distinguished by Adler and Borys (1996) and reinterpreted by Ahren and Chapman (2004) in their application of the framework on MCS.

## 1.4 Definitions

Swedish terms that are used in the thesis have been translated to English, which may cause confusion. Thus, this section aims to eliminate any confusion by providing the original terms.

- Act on system of choice - Lagen om valfrihetssystem (LOV)
- Free healthcare choice - Vårdval
- Procurement system - Upphandlingssystem
- Qualified medical care - Kvalificerad vårdåtgärd

However, when referring to specific organizations and meetings, their Swedish names have been used.

- Stockholms läns landsting (SLL) - County council of Stockholm
- Stockholms Läns Sjukvårdsområde (SLSO) - Health care within SLL
- Arbetsplatsträff (APT) - Workplace meeting

## 2. Theory and Previous Research

### 2.1 Literature Review

#### *2.1.1 New Public Management*

NPM is an umbrella term for the ideas that have influenced the reform in which public service organizations move towards management models typically adopted by the private sector. NPM was coined by Hood (1991, 1995) and he was considered to be one of the most prominent founders of what was considered to be the “gold standard for administrative reform” during the 90’s (Farazmand 2006). The belief that shifting from a rigid hierarchical bureaucracy to a more business-like management would induce efficiency was the reason that the reformative ideas had such a significant impact.

NPM replaced the previous accountability paradigm of Progressive Public Administration (PPA). Following the transition, a new conception of public accountability was introduced which implied moving away from rules and procedures intended to minimize corruption and thus tax waste, towards accounting dependent control. The mistrust of the market and private business methods in the previous PPA model was thus redirected towards the public employees. Since public employees were considered to be budget-maximizing bureaucrats, their activities needed to be scrutinized and carefully evaluated by accounting techniques. As a result of the evolution of NPM, the emphasis in accountability shifted from processes to results, i.e. from *how* the work was done to *what* they achieved, and differences between the public and private sector have been reduced or removed (Hood, 1995).

#### *2.1.2 New Public Management in Health Care*

Lisa Kurunmääki (2004) found that medical professionals in Finland had acquired financial expertise which was hybridized with their medical expertise. This had several implications for the employees, as physicians had to use economic rationality when expressing their needs in order to ensure that their voices were heard (Kurunmäki, 1999). Furthermore, the study showed how the increasing emphasis on accounting tools affected physicians. In fact, the tools became instructions and thereby a power device when the knowledge of accounting amongst medical staff was deficient. According to the study, the findings also held for Swedish medical practitioners.

Following the NPM paradigm, the fraction of financial measures in the MCS of health care centers has increased. Thus, focus has shifted from quality to financial performance. This challenges the professional identity of physicians, since their basic objective is not captured by quantitative measures but rather qualitative ones (Strandberg-Larsen et al. 2006). Moreover, physicians have expressed their need for less administrative work and a closer contact to patients and colleagues, which has been difficult to attain with the new business methods brought by NPM, such as performance measurements (Brorström et al, 2008; Mannion et al, 2007). The extended use of performance measurements has increased the time needed for registration, and the augmented pile of administrative work has shown to demotivate medical staff as it exhibits a shifting priority from quality to goals (Østergren, 2006). Despite the fact that public sector managers have rated qualitative measures as very important, a study by Lee (2008) on performance information has shown that they were highly undeveloped.

In conclusion, prior studies reveal numerous issues regarding the effects of NPM on medical professionals. This underpins the value of our research question, as the use of enabling control would allow employees to influence the MCS, which may mitigate these issues.

### *2.1.3 Enabling and Coercive Control*

Using research on the design of equipment technology, Adler and Borys (1996) pinpointed two types of formalization - enabling and coercive. The coercive formalization is used in an attempt to induce efficiency and is commonly recognized by the top-down control approach containing standardized operation procedures, formal rules and preplanning, all emphasizing centralization. As the competitive markets have become increasingly complex, organizations tend to develop from the traditional industrial mechanistic machinery focused on economies of scale, to granting flexibility and trust in employees to be more responsive to unexpected events. Thus, it is important that the MCS enables a healthy balance between efficiency and flexibility. To achieve such a balance, Adler and Borys (1996) developed the typology of enabling control which includes four design principles recognized as repair, internal transparency, global transparency and flexibility. These are explained in further detail under section 2.2.1.

According to Ahren and Chapman (2004), Adler and Borys' (1996) formalizations can be used as a theoretical framework which may generate a better understanding of how operational work processes can be enhanced and rendered more efficient through the flexible efforts of local



employees. Thereby, Ahren and Chapman (2004) reinterpreted the notions of enabling and coercive control, and applied them to their study of MCS in a restaurant chain. This reinterpretation will be used as the foundation for our study of MCS in the health care sector, combined with the original definitions of Adler and Borys (1996).

## 2.2 Theoretical Framework

### *2.2.1 Enabling Control - Repair*

The repair principle emphasizes the need to dissect control processes and to provide users of the control systems with capabilities for fixing them. As a prerequisite, workers must be trusted and encouraged to give feedback and communicate their concerns with organizational rules and standards. This allows employees to tailor the standards to differences in their local environment and thus improve the level of usability of the standards and rules.

To be able to repair the control systems, the users need to understand them. Thus, dissection of operational rules and standards from the complex accounting language to comprehensible and relatable metrics is of utmost importance.

### *2.2.2 Enabling Control - Internal Transparency*

The effectiveness of repair is connected to the employees' capability to analyze control systems, which is dependent upon the internal transparency. Internal transparency aims to render internal processes visible through the flow of communication and information within the organization. In the case of a coercive approach, employees are not believed to be in the need of internal transparency in order to succeed with their tasks. Thus, information about the status of the processes or understanding the internal functioning of the various processes is considered to be unnecessary.

In contrast, the enabling approach stresses the importance of the employees' understanding of the internal functioning of various processes, as well as the degree to which they are updated of their existing status, to be able to deal with unexpected events. The enabling formalization clarifies the employees' tasks, ensures that they understand the functioning of their tasks and provides feedback to them. A high level of internal transparency would imply that rules and standards are related to the operation, which will be reflected in employees' level of understanding of how they contribute to the final outcome.

### *2.2.3 Enabling Control - Global Transparency*

Global transparency relates to the employees' understanding of the organization's broader system. The coercive school of thought believes that employees are solely responsible for their department and are not expected to look beyond the horizon. Instead, understanding the broader system is considered to be the management's responsibility which gives rise to asymmetrical global transparency.

The enabling approach, on the other hand, provides a comprehensive view of the organization as a whole. Not only are the employees' own contributions to the whole system understood, but they are also informed of the status of the entire production/service process. This enables them to figure out how they fit into the complex broad organization and thus expands their potential to recognize improvement opportunities. Budgets are typically used to enforce global transparency. Budgets and targets are also used as a coordinating tool between units, communicating how the various units should prioritize.

### *2.2.4 Enabling Control - Flexibility*

The principle of flexibility refers to the degree to which employees are able to use their discretion when conforming to the control systems. The evolution of technology has contributed with various methods of control systems which may engender flexibility. For instance, control system routines and data can be customized both for the user and the recipients in the organization. Allowing discretion can create different aggregations of the same information, which in turn forms differing yet interrelated mental maps of the organization that are specific to various changing circumstances.

The enabling approach allows discretion as deviations from procedures are not considered damaging but rather beneficial to provide learning opportunities and to create new mental maps. Thus, employees are allowed to tailor parts of their work after their preferences. In contrast, the coercive approach minimizes discretion and expects employees to perform their tasks in line with standard procedures.

### 3. Design and Research Methods

#### 3.1 Comparative Qualitative Case Study

As the research question focuses on MCS from the perspective of the individual employees in private vis-a-vis public health care centers, the quantitative aspects of the MCS are not as central. Therefore, a comparative qualitative case study has been conducted where the focus lies in the employee's perception of the extent to which the systems are characterized by enabling or coercive control. As qualitative research analyzes information conveyed through both language and behaviour in a natural setting, it has the potential to capture expressive information not conveyed in quantitative data (Berkwits & Inui, 1998). Therefore, it is argued that using a qualitative method will allow for details and nuances that are essential for the study to be recognized and is thus the most suitable methodology.

#### 3.2 Selection of Study Objects

In order to prevent the study from being compromised by factors unrelated to the thesis question and thus to ensure comparability, the two health care centers have been handpicked to be as similar as possible. Thus, they both had to provide health care on behalf of SLL. Other factors were taken into account such as size, which was measured by the number of listed patients. The number of listed patients for the chosen public and private care center was approximately 7000 and 9000, respectively, and thus appropriate for comparison. The type of care provided was also important as we wanted the operations to be as similar as possible. The chosen study objects satisfied all of these criterias for comparability. In addition, we wanted them to have a similar relationship to a larger organization. The reasoning behind this is that any unit that is part of a larger organization will be controlled differently compared to a single isolated unit (Chenhall, 2009). More specifically, factors such as comparability within the entire organization become more important. Since all public health care centers are part of the large organization SLSO, it was important to find a private health care center in a similar position. Thus, one of the largest private actors in the county of Stockholm, Capio, was chosen for comparison.

The real names of the health care centers, within SLSO and Capio, have been replaced with pseudonyms in order to ensure full anonymity. This was important in order for the interviewees to feel comfortable and speak openly about issues related to their MCS. Thus, in the following

study, the public health care center will be referred to as Alpha and the private health care center will be referred to as Beta.

### 3.3 Data Collection

#### *3.3.1 Interviews*

Interviews are one of the most prominent and valuable sources of information for qualitative case studies (Yin, 2003). Thus, the primary source of data was interviews conducted with employees from each health care center. In order to obtain symmetry and comparability between the health care centers, the study strived to include personnel from the same organizational levels. In total, ten interviews were conducted with five interviews in each health care center. In the public health care center, the operations manager was not available for an interview. Thus, the assistant operations manager was interviewed instead, along with the local controller, the head of controllers, a doctor and a nurse. On the private side, the positions held by the interviewees were operations manager, controller, doctor, nurse as well as assistant nurse. Due to the struggle to attain perfect symmetry between the interviewees' positions in the two health care centers, a compromise was made. Since it was difficult to obtain an interview with an assistant nurse from the public health care center, the fifth interview was conducted with the head of controllers instead. This compromise seemed appropriate as the local controller had been employed rather recently.

The controllers were interviewed first, which provided a more holistic view of the MCS in each organization. Furthermore, these interviews created a solid foundation from which relevant interview questions to other employees at various levels could be formed.

On average, the interviews lasted approximately 70 minutes. Most of the interviews took place with both researchers present and were recorded digitally. The interview questions were semi-structured, which facilitated active listening and fruitful follow up questions. The complete transliteration was made shortly after the interviews were over. Complementary notes were also taken during the interviews where both researchers were present. Occasionally, when the interviewee did not have a specific piece of information in mind or when uncertainties arose after transliteration, follow up questions were sent per mail.

### *3.3.2 Other Data Sources*

According to Ryan et al. (2002), using various informational methods and sources can be advantageous. Therefore, secondary sources were used to complement the interviews. For instance, information was collected from the two organizations' websites when preparing for the interviews. Moreover, other internal documents were gathered, such as internal budgets and information regarding financial models.

### **3.4 Methods of Data Analysis**

The analysis was done parallel to the data collection. As soon as each interview was transcribed, the information was processed, analyzed and reflected upon. The empirical data was then structured into five categories, namely after the four pillars of enabling control, as well as any additional background information necessary to understand the organizational context in which these pillars exist. Following this categorization, each pillar was compared and analyzed in order to detect any similarities and differences between the private and public health care centers. To be able to explain the perceived similarities and differences, theories extending beyond MCS were also extracted in order to understand the mechanisms affecting the experience of the individual employee, such as the field of psychology. Ultimately, an abductive reasoning was applied where the authors continuously switched between theory and empirical data in an attempt to make sense of the data and to answer the research question.

### **3.5 Validity**

Validity refers to how accurately the data reflects the world (Ryan et al. 2002). Gaining such objective truth can be a struggle as qualitative interview methods are bound to be embedded with the interviewees' subjective interpretations of their own organization, as well as the authors' subjective interpretation of the interviews (Brunsson, 1981). Subjectivity is inevitable as this study is intended to gain insights into how nuances and details of MCS can affect employees on an individual level. This makes generalizations made out of qualitative case studies difficult. However, the method is considered to be powerful in generating analytical knowledge where hypotheses fruitful for further examination with larger samples can be found. (Ryan et al, 2002; Yin 2003).

In order to increase the validity of the study, a systematic approach was used as similar questions were asked to the employees that were at the same level in the two organizations.

Furthermore, to decrease the authors' subjective interpretations of the interviews, Yin (2003) proposes that multiple data sources should be used. This was done as secondary sources validated and complemented the information gained from the interviews. However, it is important to note that the empirical material that was collected from each health care center was affected by the interviewees' subjective interpretations of the questions, which provoked very different examples. As the conclusions were drawn on the basis of these answers, and thereafter used for comparison, the validity of the conclusions may have been flawed.

### 3.6 Reliability

Reliability refers to the repeatability of findings, i.e. if the outcome of the study would be the same if it was replicated and reproduced by someone else (Ryan et al. 2002; Yin, 2003). However, as Brunsson (1981) explains, every researcher has their own language which makes reliability difficult to obtain. Nevertheless, this can be mitigated by using a case study protocol where the course of action is documented (Yin, 2003). Therefore, the authors prepared thorough interview templates and documented the answers both manually and with digital recorders. Shortly afterwards, the interviews were transcribed on a detailed level.

## 4. Empirical Findings

### 4.1 Free Healthcare Choice

In 2009, the act (2008:962) on system of choice was introduced as a new alternative law to the traditional procurement system. Since 2010, however, it is mandatory for all county councils within the area of primary care. Thereby, consumers and patients are permitted to choose freely between all health care providers. As a result, the competition amongst health care centers has increased significantly (Konkurrensverket, 2014; Ekonomifakta, 2017). By encouraging an increased degree of rivalry, the government wanted to put pressure on health care providers to become more efficient in their use of resources and increase the quality level of their services. In the case of failure to increase efficiency and quality, unhappy patients are likely to list themselves at another health care center which would reduce revenues. A change of listing is not only simple, but also free of charge, and the fee that is charged per visit is independent of the health care center that the patient chooses. Thus, switching costs for patients are rather low, which fuels the competitiveness amongst health care centers who are forced to compete on the basis of quality rather than price (Konkurrensverket, 2014).

### 4.2 Alpha Health Care Center

#### *4.2.1 Background*

SLSO is a separate entity within SLL and is responsible for the health care in Stockholm County. SLL acts as the principal and forms frameworks from which SLSO forms its own budget. This budget is then used as a framework from which each health care center forms its own budget. The main goal for each unit is to balance its budget so that revenues and expenses equal zero, i.e. to attain a zero-budget. Thus, how the budget is formed is highly dependent upon the generated revenues, which in turn are reliant on the contract with the purchaser HSN. Each health care center has a certain level of freedom in achieving the final goal of zero on the bottom line. Hence, a health care center may increase its revenues or decrease its expenses in order to achieve its financial goal, without the intervention of SLSO in this trade-off (SLL, n.d.).

According to the head of controllers, the financial outcome is compared to the budget set on a monthly basis, and the deviation is then reported to SLSO that analyzes the consolidated reports

and forwards them to the top management. If a profit is generated, it goes back to SLL. If the health care center makes a loss, a thorough examination of the underlying causes is done.

In the budget, certain KPIs are tracked to measure the operative and financial health of Alpha. When looking at the cost side of the equation, personnel and lab costs are the most significant cost drivers. As the local controller of Alpha explained, almost 80 % of the costs are driven by personnel and 5 % are directly related to medicine and lab costs. Since personnel has such a significant impact, the appropriate amount of staff is vital. Therefore, they follow metrics such as listed patients per doctor. The number of employees is thus determined by the number of listed patients. In order to cover the doctors' salaries, a daily goal of 12 patient visits per doctor is usually set, although the number of patient visits varies across the occupational groups. When tracking lab and medicine costs, they use cost per lab visit and the aim is to lower this ratio as much as possible. As of right now, 150 SEK per lab visit is a reasonable and expected outcome, according to the local controller. Although there are goals for the KPIs, these are not considered to be predetermined targets. Rather, the outcome of the KPIs is used for benchmarking, i.e. to compare each unit's performance to the average (SLL, 2018).

#### *4.2.2 Repair*

The assistant operations manager described the MCS as a complex one, with many measures imposed on the health care center from SLSO. The numerous measures felt excessive, as there was not enough time to dig deeper into the numbers and thereby enable the workers to use the results for improvements of work processes. Moreover, if she had the opportunity to design the MCS on her own she would have chosen to shift the weight from quantitative to more qualitative measures as the latter was considered to be more pertinent for the operation. Nevertheless, she was unable to repair the control system as it was strongly dependent upon the remuneration model of HSN. Unless the remuneration for the number of visits decreases even further, in relation to the remuneration for the number of listings, the focus on quantitative measures will remain. In fact, Stockholm is the only county in Sweden in which the fixed remuneration for the number of listed patients is not the dominant source of revenues. In the remaining counties of the country, it represents 70-99 % of the total revenue (SKL, 2018). As the incentives imposed by the remuneration model of HSN go far beyond the workers' area of control, the users of the control system are not provided with the capabilities to deal with the perceived issues in the current system.



Since a prerequisite to repair is trust in employees, along with a well-functioning feedback system which encourages workers to communicate their concerns with organizational rules and standards, this was one of the key subjects during all interviews. When asked how suggestions for improvements in the work processes usually arose, all employees agreed that they came from above and not from the local workers who actually have hands-on knowledge about their daily operations. The employees explained that local suggestions were rarely brought forward due to the distinct hierarchy in place, which was characterized by a top-down control with many directives coming from above.

Furthermore, the employees described the administrative work as a heavy burden which is very inefficient. When asked what they currently do to improve their work processes, an employee answered that nothing is being done. He explained that he wanted them to take action, but added that Alpha had little power in the matter as the IT-system and rules are determined by SLL. Despite the desire of workers to change the standards and rules concerning the administrative work, reactions amongst decision makers at the higher levels have been limited. One of the employees explained that workers could try to influence the current rules and standards by expressing their opinions and asking their managers to forward these improvement proposals to their managers. However, he did not believe that the operations manager could do anything about it, and neither could the regional manager.

*“There is pressure coming from below, but it feels quite unfruitful as there are many steps that need to be taken before something will happen [...]. My voice is not really heard.”*

For instance, patients could be asked to fill in an inquiry online before coming to the health care center where they would describe their medical history and current issues. This would reduce the time required to process such information at the health care center and thereby render the work process more efficient. Despite the workers’ desire to implement the system, nothing had happened so far.

Thus, it is generally managers at the higher levels who can initiate change and there are limited possibilities for employees at the local level to improve the rules and standards which guide their daily work. As a consequence of the limited possibility of workers to repair the current system, they have had to bend the rules in some cases in order to make ends meet. One issue that the assistant operations manager brought to light was the cap in the remuneration model

which limits the number of housecalls that they can make per patient on a yearly basis with full compensation. In accordance with the system, each housecall generates a revenue of 240 SEK. However, they are obliged to repay 33 % of the compensation if the limit is surpassed. As the limit is determined by the number of listed patients, and not the needs of the patients, Alpha exceeded their limit last year and had to repay 300 000 SEK to HSN. As some of their patients require several housecalls per day, the repayment to HSN becomes inevitable.

*“My manager has spoken to them (HSN). We cannot deny our patients care because our budget does not allow it. We cannot tell a patient that we will not come to your house because we have already exceeded the limit. It is not possible, but they have said that the terms in the agreement are fixed and we cannot influence them.”*

Hence, the workers feel morally obliged to help their patients who are in need of care, as it is their duty as medical professionals. However, they are held responsible for the deviation from the prescribed limit, although they are merely satisfying their patients' medical needs. In other words, they are assigned responsibility for the number of housecalls that they make, despite the fact that the number of housecalls that their patients need is not within their control. Alpha has tried to change the situation, together with many other health care centers, without any success. Last year, HSN responded that they would reconsider the terms in the contract until next year, but nothing has happened so far. Thus, workers have figured out their own ways of providing the demanded quantity of medical services, while making financial ends meet.

*“We may have bent the rules and registered housecalls differently, because if a patient demands four visits per day, the person really needs it.”*

Despite the observed difficulties in enabling employees to tailor the standards to differences in the local environment and thereby improving their level of usability, such obstacles have occasionally been overcome. In February, SLL pressured Alpha to extend its opening hours by 5 hours per week, while offering an additional monthly remuneration of 15 000 SEK. Alpha stated that they did not want to change their work as they perceived the compensation to be insignificant and the terms to be inappropriate due to their difficulties in satisfying the need for personnel. As a result of the feedback, SLL withdrew the new terms and acknowledged that it had gone so fast that they had not even consulted the health care centers that were concerned. Hence, the workers managed to repair the system.

#### 4.2.3 Internal Transparency

A prerequisite to repair is internal transparency, which represents the foundation of information that enables employees to repair the MCS. Thus, it becomes important for the employees to understand the internal functioning of various processes and how they contribute to the overarching goals. As stated by the head of controllers, the budget has been dissected into metrics which are relatable to the daily operations of employees. This is done with the aim of providing goals for each occupational group as well as keeping all employees updated through follow ups. The following example was provided:

*“We have calculated how each doctor can contribute to the goal of reaching a zero-budget. For example, we have calculated that each doctor should be able to receive 12 patients per day.”*

Although efforts had been made to communicate the targets to employees in a pedagogical manner, by dissecting the complex accounting language into relatable figures, the information had not reached all employees. In fact, one of the employees was unaware of the target of 12 patients per day. Ultimately, the dissection of the budget is an enabling school of thought, but the practical use of it fell short due to poor communication. In fact, information pertinent to the employees’ daily work was stuck at the higher levels of the organization. For instance, each unit is compensated differently based on the diagnoses of their listed patients, i.e. care burden. Although the calculations of the compensation system are not directly reliant upon operative employees’ involvement, their understanding of the compensations would enable them to provide feedback to the MCS and ultimately repair it. In this case, however, the doctor was uninformed of whether care burden is compensated or not.

Nevertheless, the unit had an effective flow of communication internally. Through collegial meetings held every week, each occupational group discusses contingencies and share information regarding best practices and improvement proposals. Additionally, they hold APT meetings every month where controllers present information about the budget and how well the units are performing financially. While the employees had been informed of the financial performance of Alpha, their understanding of the budget turned out to be flawed. In the conference room, Alpha had a budget hidden behind cabinet doors which all employees had

been exposed to according to the assistant operations manager, but the interviews with the operative employees showed that this was not the case.

However, the lack of deficient knowledge regarding the budget did not seem to affect the employees' understanding of how deviations in their daily work alter the financial outcome. In fact, they knew which choices that were preferable from a financial point of view. For instance, they understood that it was better to diagnose a patient's issues through patient meetings rather than doing so through lab examinations. These matters are brought up for discussion during their collegial meetings which indicates enabling and valuable internal communication within the unit.

Monthly meetings are also held amongst controllers. They discuss the current state of their units and bring forward issues regarding data registration. As an example, discussions regarding incorrect registrations related to sick days for doctors have taken place. In addition, they use a software named Clickview which gives every controller an update on the exact status of each unit's KPIs.

Setting aside the fact that not all employees had seen the budget, the internal communication was generally in line with the enabling school of thought. Similarly, the communication amongst controllers showed enabling tendencies. Issues tend to emerge in situations where information should be transferred from one department to another.

#### *4.2.4 Global Transparency*

Connectivity between units in the organization is fundamental in order to achieve global transparency (Ahren & Chapman, 2004). Achieving connectivity for an organization as big as SLSO given the free healthcare choice turns out to be a challenge. Generating a cooperative environment where each unit has the concerns of other units in mind becomes increasingly difficult as they now compete for listed patients. Such internal competition has shown to decrease information sharing (Bloomberg, 2009).

The market conditions turned out to impair the global transparency in this case as well, as the level of information sharing was suboptimal. When asked to elaborate on opportunities to share knowledge between the units, the nurse did know about interaction meetings, where operations managers and representatives for each occupational group from each unit meet and share

information. However, this was done in the absence of operative employees. This reduces their ability to engage in the discussions, which in turn limits their exchange of both concerns and best practices regarding several questions, one of them being MCS. The operative employees' absence during these meetings may have contributed to their lack of knowledge regarding their role in the broader health care system. For instance, neither of the operative employees understood the relationship between their unit and the purchaser HSN.

Through the interaction meetings, where operations managers and representatives for each occupational group from each unit share information, operative employees may contribute with inputs through their representatives. Moreover, the controllers of SLSO have network meetings where they share information and opinions. Occupational group meetings are also organized for operative employees. However, these meetings rarely touch upon questions regarding the MCS, which differentiates these meetings from the interaction meetings and the network meetings. Thus, coercive tendencies can be discerned as the operative employees are solely responsible for their tasks, whereas the responsibility of understanding and overseeing the broader system becomes exclusively the management's job. Hence, asymmetrical global transparency emerges. This is reinforced as the controller of Alpha stated that the employees do not focus on MCS at all, they focus on their primary tasks only. This indication of coercive tendencies was further strengthened when discussing the appropriate employment level. Although the employment level is under the operations manager's responsibility, it represents the greatest cost driver which should make it relevant for the budget. However, when asking the controller about how the appropriate level is determined, he instantly referred to the operations manager as this was considered to be her job - not his.

*"Ask her because we don't follow that as controllers, we follow the budget."*

While acknowledging that the controller had entered the organization quite recently, this statement underpins the pattern of coercive tendencies where understanding the broader system is not to be expected. However, there were signs of information sharing and enabling tendencies. As mentioned in the section 4.2.1, benchmarking is used in an informative way. The benchmarking numbers are shared every month with the operative employees, which allows them to gain insight into the complex broad organization and thus expands their potential to recognize improvement opportunities. It was also used as a coordinating tool,

communicating where the various units underperformed and thus how they should prioritize their work.

#### *4.2.5 Flexibility*

In order to meet the target number of visits per day, a regular visit should not take more than 30 minutes. However, unexpected events often occur in the daily work of employees. During a visit, for instance, a wound may turn out to be more severe than expected and thereby the employee needs more time than initially planned. If the situation is urgent, the worker may have to prolong the meeting in order to complete the procedure. In most cases, however, the patient is sent home at the end of the scheduled meeting and is booked for a new one, instead of dealing with the issue directly. Hence, workers are often unable to flexibly deal with contingencies without deviating from the target number of visits built into the schedule and thereby compromising the efficiency parameters. While this example demonstrates a lack of flexibility in the current work processes, it also reveals the workers' limited ability to repair such processes. The assistant operations manager wanted to do things differently, by handling unexpected events in a more flexible manner and enabling workers to deal with issues directly instead of systematically booking new meetings. As a result, patients who are sent off after 30 minutes regardless of whether or not their issues have been resolved tend to become upset. She described the current work process as inhuman and mechanistic.

Nevertheless, the lack of flexibility in the schedule, as a result of the rigid remuneration system, did not permeate the actual care of the patient during the visit. The doctor explained that once he had accommodated the patient in his room, he was able to make his own decision of how to handle the situation based on his knowledge and tailor parts of his work after his preferences. For instance, when patients reveal that they suffer from several disorders during the meeting, he usually books a new meeting on his own instead of going through the assistant operations manager who is in charge of the schedule. By deviating from the standard procedure, he could speed up the process by finding a time slot on a shorter notice and informing the patient about it directly. Discretion was also allowed when dealing with patients who are late to their meetings. The doctor had put up his own deadline of 10 minutes, after which he chose to not accommodate the patient in order to prevent excessive stress and meet the remaining target number of patients on the schedule. Thus, the standard procedures should be seen as guidelines, rather than coercive rules.

*“I am not so hampered by rules and standards. Not when I meet patients. I am allowed to make my own judgements in my daily work.”*

When discussing the administrative burden with one of the operative employees, he had an idea of how to optimize the work process by taking a picture of a wound instead of writing a description of it in the journal. This would be much less time consuming and would allow the same information to be aggregated in new ways. However, this idea was not brought forward as he did not expect any response from managers at the higher levels.

Thus, the enabling approach to flexibility appears to be moderately present as the individual employee's discretion is allowed in the meeting with the patient. However, the absence of alternative methods to conform to the MCS indicates a lack of flexibility. Moreover, the health care system as a whole imposes coercive constraints on Alpha as it limits their ability to adapt operational processes to local circumstances.

*“It rarely feels like the unit (Alpha) limits my work, but rather the health care system as a whole.”*

## 4.3 Capio Beta Health Care Center

### 4.3.1 Background

Capio Group is an international company within the health care industry and has 23 health care centers in the Stockholm region. The group executive board is ultimately responsible for setting directives and guidelines which all Capio units are expected to follow. The primary directive is their financial model, which is founded on the belief that providing high quality care to patients will drive financial success. Financial success in the area of primary care is considered to be 0-10 % profit. As high quality care is deemed precedent to profit, the budget contains not only KPIs but also QPIs. Certain metrics are followed in request of HSN (SLL, 2015). These are however complemented by many of the Capio's own metrics. The remuneration system of the purchaser applies to all health care providers in Sweden, which strongly affects the formation of their budgets.

The budget is followed on a monthly basis, where a thorough analysis of the outcome and the budget is performed. This is done on various levels of the organization, from unit to group level, to monitor their performance and detect unexpected trends (Capio, 2018).

The QPIs followed in Capio are divided into three dimensions: PROM (Patient Reported Outcome Measurement) measures the patient's perceived results of the medical care. PREM (Patient Reported Experience Outcome Measurement) follows patients rated overall experience of the visit. CROM (Clinical Reported Outcome Measurement) measures the clinical reported outcome (Capio, 2015). These dimensions are followed in Capio Beta with the aim to gain a comprehensive view of both patients' satisfaction and medical results. Moreover, the QPIs are considered to be leading metrics that will eventually influence the KPIs. For example, the better the quality of the care, the faster recovery time from treatments is expected, which will eventually decrease the time needed per patient visit (Capio, 2018). The time needed per patient is measured by the KPI known as average length of stay (AVLOS). Examples of other KPIs that are expected to be affected by the outcome of the QPIs are number of listed patients, cost per lab visit, as well as the number of patients considered to have received qualified medical care. Qualified medical care generates twice the revenue of a regular visit and is classified as visits where the patient receives care for an additional issue which was not initially scheduled for.

Some of the mentioned metrics are followed on an individual level. Subsequently, these are aggregated to a team level, so that Capio Beta can be measured on the outcomes of the metrics as a unit. This is done for every Capio unit, and the outcomes are then used for benchmarking to compare each unit's performance to the average (Capio, 2018).

#### *4.3.2 Repair*

According to Capio Beta's controller, the idea of making a profit in the health care industry is difficult to accept amongst some Swedish citizens as they consider it to be unethical. As a listed company, however, they must seek to generate a profit for their shareholders. Consequently, Capio developed a financial model which focuses more on satisfying their patients' needs in order to boost their financial results. The controller explained that some of the KPIs which had been stressed heavily before, did not fully correlate with the result on the bottom line. More specifically, Capio had previously focused too much on the productivity of each doctor, i.e. number of visits per week or day, without considering the whole picture including the



associated use of resources and the number of patients taken care of in total. According to the controller, this became counterproductive as other relevant parameters were neglected in the process. When the issue was identified amongst the workers, they provided feedback to the controller who reshaped the control system. Instead of merely focusing on the productivity of each individual, the controller now puts more weight on the entire team's productivity, i.e. how much Capio Beta produces as a whole and the resources that such a production requires.

However, many generic KPIs, formed by the top management of both Capio and SLL, are used to enable comparability across the various health care centers in the entire Capio group. Consequently, some are not fully relevant for each health care center. This was supported by the operations manager, who also considered some measures to be misrepresentative of their true performance. As an example, she brought up the measure of accessibility. Although considered as an important metric, the method used to measure their performance did not reflect the actual service that they provided. According to her, Capio Beta receives approximately 150-170 calls per day. SLL has an automatic dial-up, where 10 calls are made per month to evaluate the health care center's accessibility. The target has been set at a timeframe of 90 minutes, which means that if 2 out of 10 calls in one month are made after 90 minutes, the measure will show an accessibility of 80 % that month. If the accessibility over the course of a year is below 85 %, the health care center will receive a fine from SLL. She described the target, given the poor measures, as quite impossible to attain and incredibly frustrating. When their accessibility was measured with Capio's own system, TeleQ, they had an accessibility of 85 %. Thus, she asserted that SLL's measure was flawed.

Other measures that the operations manager perceived as misrepresentative are continuity and listed patients per doctor. The mutual denominator in both issues was the scarcity of regular doctors, as many of them have chosen to work as medical locums instead. Capio Beta is one of the health care centers that has suffered from difficulties in recruiting regular doctors in the past. Since the source of the issue is on a societal level, which goes beyond their area of control, continuity as a measure of quality is problematic as it measures the extent to which a patient gets to meet the same doctor over time.

Similarly, SLL's measure of listed patients per doctor becomes questionable due to the increasing fraction of medical locums. The patient may either be listed at the specific health care unit or a specific doctor. However, the health care center is not allowed to list its patients

on medical locums. Since Capio Beta, up until recently, has filled its schedule mainly through the service of medical locums, the only option has been to list them on the health care unit. However, when patients cannot find appropriate time slots at Capio Beta, they go to other health care centers instead and often list themselves there in the process. Thus, the local circumstances have led to an increased difficulty in meeting the objectives with the current suboptimal measures.

*“Sometimes I wish that I could get some space to work with this anyway, without the pressure of a measure that feels unreasonable”*

Despite these shortcomings, the employees agreed that their MCS generally worked well, as deficient components had already been repaired by its users. The operations manager explained that the employees may affect the budget indirectly by expressing their opinions and ideas on a daily basis. By taking into account the informal feedback provided by her employees, she can adjust the budget accordingly. For instance, the target for a doctor was set at 20 patients per day when she started working at Capio Beta. Since this was considered to be too high amongst workers, the target was lowered, which demonstrates the workers’ ability to influence the MCS. The ability of workers to repair the current system was also accentuated by the nurse who stated the following:

*“If there are rules or standards that do not fit, we will notice it and change them after evaluation.”*

For instance, “Bättre besök” is a new system in Capio Beta which was introduced as a response to the workers’ call for less administrative work. The system enables patients to fill in an inquiry online, prior to the visit at the health care center. By providing information regarding their medical background and current issues, the time needed to process this information at the health care center was decreased. Hence, the work process was optimized as a result of the workers’ feedback.

#### *4.3.3 Internal Transparency*

The budget of Capio Beta has been dissected to relatable goals and metrics for the operative employees to enhance their understanding of how they can contribute to the overarching goal. It also gives the employees updates on the status of their procedures. The operations manager

believes that this will enable the employees to become more involved in issues related to the MCS by encouraging them to provide feedback regarding their relatable parts of the budget.

The dissection was successful in informing the operative employees regarding what metrics their occupational group are evaluated upon and how variations in their activities affect the outcome of these metrics. However, there was a lack of cognizance of the unit's overarching goals, indicating limited comprehension of how the outcome of the occupational group's metrics affect the unit's goals. According to the controller, the shortfalls are common in the health care industry as operations managers generally do not have a financial background. Consequently, they may feel uncomfortable in situations where they are expected to inform all employees about a subject in which they lack full comprehension. Hence, the flow of communication becomes suboptimal.

To further support the intended encouragement of feedback from operative employees, the operations manager asks them on APT meetings one month prior to the formation of the budget whether they have any requests or inputs for the budget. Other initiatives have been taken to involve the employees to a greater extent. Once a month, they hold "apprentice occasions". Prior to these occasions, employees can express their desire to deepen their knowledge in certain areas. During these meetings, there are also discussions on how the acquired knowledge of the meetings could aid them in improving routines and procedures. Booking issues was a topic which had been brought up on these occasions. However, the actions taken with the aim of expanding the knowledge of those who were responsible for the bookings went beyond the meetings.

*"One period, we had people behind the reception who did not have enough medical competency, although they were really good employees. We decided to learn from this, so after every morning shift we had a nurse who went through the bookings with them, pointing out why some were good and why some of them were not. The assistant nurses really learned a lot from this."*

In addition to the apprentice occasions, Capiro Beta also has occupational group meetings twice a month where members of each group can discuss contingencies and best practices.

The dissection of the budget, combined with the mentioned initiatives, show clear intentions of enabling control. The efforts have enabled the employees to acquire information which aids them in understanding the internal functioning of processes and procedures. They have also been successful in keeping the employees updated of their existing status and providing information fruitful when dealing with unexpected events. However, some of the intentions did fall short in practice. As mentioned, Capio Beta aimed to enhance their employees' understanding of how they contribute to the overarching goals and involve them in dialogues. However, both attempts turned out to be unsuccessful.

*“There is a paper on our fridge with suggestions of different subjects for our upcoming apprentice occasions. Recently, there was nothing written on the paper and I tried to encourage people to write something, but they are not so motivated to contribute.”*

#### 4.3.4 Global Transparency

Each term, new employees attend “This is how we do it” events where the CEO and regional managers inform them about the organization as a whole. This indicates that they value enabling global transparency, which is elaborated upon by Capio Beta's operations manager:

*“It may not be important for the patient what name is written on the door, but for us workers it is. I do believe that everyone understands the entire organization and feels like they are a part of it.”*

However, the success of these initiatives may be questioned as the employee without any management responsibilities did not understand the system as a whole. For instance, the employee did not know the responsibilities of HSN.

The free healthcare choice has increased the competition between health care units (Konkurrensverket, 2014). However, Capio's units still show signs of extensive cooperation. For instance, every other month occupational group meetings are held where representatives for each group attend to discuss issues and share information. However, since the operative employees are not present during these meetings, their ability to absorb the information is limited. Therefore, other initiatives have been introduced where operative employees may participate. For instance, Capio Academy is an initiative where employees with specialized

knowledge have been encouraged to offer lectures for employees from various Capio units, who are interested in learning more about their area of expertise. The cooperative culture was further demonstrated by the use of a coordinating platform named “Pulsen”. Through this platform, employees had the possibility to ask questions and get responses from various perspectives. Furthermore, best practices are commonly shared on this platform. These structured ways of enhancing cooperation and coordination between units increased the informal flow of information as well. After the paradigm shift initiated by SLL, where HSN went from compensating doctor visits more than nurse visits to almost equalizing the compensation, Capio Beta initiated a reconstruction of their unit. Changes in both work procedures and control systems had to be done. The initiative, called “Lättakuten” was shown to be successful and was shared through “Pulsen”. Other units were intrigued by the successful adaptation to the paradigm shift and requested a visit to Capio Beta. This was elaborated upon by the operations manager of Capio Beta:

*“We started in February 2016 and the changes led to a financial success. The message was spread through the Capio units and others where intrigued to join this trend we created. We responded: absolutely, we can educate and show you. So then employees from other units visited our unit and observed our new routines in real life, as they had previously seen them on our platform Pulsen. Later, they had the opportunity to implement what they had learned from us in their own units”.*

This clearly demonstrates how a cooperative culture enhances information sharing and further helps employees of each unit to understand changes and how to adapt operational as well as MCS aspects to these changes. Similarly, the operations manager and employees from Capio Beta have visited other Capio units to learn from their best practices. Thus, the connectivity between the Capio units has shown to form enabling tendencies.

In order to further enhance the connectivity, each new hire is offered a mentorship both internally as well as externally, where they meet an operations manager from another health care center in the Capio group. According to the operations manager of Capio Beta, this expands the employees’ horizon beyond their own unit.

Capio’s benchmarking, combined with their close connectivity, informs the employees about the success of their work methods and allows them to observe the success of other units’

practices. Thereby, they will understand how different processes and procedures translate into figures. Thus, the benchmarking points to enabling control tendencies.

#### *4.3.5 Flexibility*

In the face of unexpected events, workers may use their own discretion to solve issues that arise. For instance, if a patient's medical state is more severe than expected and the employee deems that it is urgent, he or she may prolong the meeting and inform the following patients that there will be a delay. Another example is when patients show up late to their meetings. According to the employees, there are no rules that determine when the patient is too late to accommodate. In short, employees may flexibly handle contingencies as they see fit.

*“Rules and standards are there to support us. I do not perceive them to be constraining, or that my own judgement in an unexpected event would differ from what the rules and standards say.”*

Employees may also choose work methods according to their preferences and are not restricted by fixed rules and policies when conforming to the MCS. For instance, Picsara allows workers to take pictures of wounds and to attach the pictures in the journal, instead of writing descriptions of them or trying to dictate as the latter alternative tends to generate many errors. The alternative was introduced by SLL, in response to the demand for a reduced administrative burden. The fact that Capio Beta has allowed its employees to utilize this alternative indicates enabling tendencies.

In addition, when taking into account local circumstances, the controller has room for flexibility as he can create new aggregations of information. As discussed in repair, however, the comparability amongst the different Capio units is deemed important which is why local adaptations may be difficult to realize in practice. Nevertheless, the controller used separate metrics specifically adapted to the county of Stockholm to follow the performance of Capio Beta, which were not reported to the top management. For example, within the county of Stockholm, the health care centers should use specific codes for certain activities to keep a detailed track of their work, which in turn gives them an additional compensation. Therefore, the content of a visit could become more important than the number of visits, as it may have a stronger correlation to the result on the bottom line. For instance, if a patient visits a nurse who discovers that the patient's issue is actually due to something else, they may discuss these issues directly. In such cases, they can use a code for qualified medical care which doubles the

compensation for that visit. It still counts as a single visit, which is what the top management will see, but for Capio Beta it is better to take two of those visits rather than taking three regular visits. However, it is difficult to communicate this to the managers at the higher levels, who are interested in comparing the various units across the entire country, which is why the local controller follows these metrics separately.

Within the given framework, enabling tendencies have been discerned since the controller, as well as the operative employees, have been able to use their discretion when conforming to the MCS. This has created new aggregations of information, which has formed differing yet interrelated mental maps of the operation.

## 5. Analysis

### 5.1 Repair

The cap in the remuneration model imposed by HSN was considered to be an issue in Alpha as it was determined by the number of listed patients, although the number of housecalls demanded was determined by the needs of their patients and the employees felt morally obliged to satisfy their patients' needs. Similarly, the measures of continuity and listed patients per doctor imposed by HSN were perceived to be misrepresentative as both had been negatively affected by Capio Beta's difficulties in recruiting fixed staff the past few years, which they could not control. Hence, both health care centers were subject to measures which included variables that went beyond their control. Consequently, Alpha had bent the rules and registered housecalls differently in order to satisfy their patients' needs while making financial ends meet. Although a similar outcome was not exposed in Capio Beta, the operations manager perceived the situation to be rather hopeless as she described the measures as "unreasonable".

The identified outcomes could thus be explained by one common denominator: the controllability principle, which was not upheld. According to the controllability principle, managers should be assigned responsibility only for the factors that they can influence (Anthony et al., 2014). Otherwise, it may cause a lack of motivation at best, which was discerned in Capio Beta. At worst, it could result in dysfunctional behavior, which was found in Alpha. These examples demonstrate one of the reasons why the notion of repair should become a key approach to enabling control.

Since the primary care industry is based on free healthcare choice, which implies that anyone could establish a health care center if the conditions in the contract are satisfied, the health care provider can only accept or deny HSN's predetermined conditions in the contract. In other words, there is no room for negotiation where the provider's preferences may be taken into account. In addition to the lack of attention to the particular health care center's needs when forming the contract, the feedback of the health care center does not appear to be prioritized, to the benefit of simplicity and comparability. The trade-off, however, is that both public and private health care centers experience a lack of repair due to the constraining frames set up by HSN.



Although employees of both the public and private health care center expressed their desire for a greater focus on qualitative measures, rather than quantitative ones, both had already witnessed this shift of focus in their MCS. Thus, the process of repairing the MCS has already been started as a result of the workers' feedback regarding the overriding relevance of qualitative measures. While Alpha and Capio Beta show similarities in this aspect of repair, Capio Beta has actually taken the lead in the process. For instance, Capio has developed its own financial model which includes an increasing number of qualitative measures, as the model is founded on the idea that quality drives profit. Moreover, an extensive set of quality measures, also referred to as QPIs, are included in the budget for careful evaluation of their services. In short, the emphasis on quality in the MCS was found to be greater in Capio Beta than in Alpha. This empirical result is further supported by Konkurrensverket (2014), whose study found that private health care centers rank "medical quality as a means of competition" twice as high as public health care providers.

The interview with Capio Beta's controller revealed that there are expectations and external pressures surrounding the company which are somewhat contradictory. In fact, the idea of making a profit in the health care industry has been a controversial subject in the public debate, while it is expected by shareholders. In response to the workers' feedback, as well as the society's expectations, Capio has tried to satisfy all requirements by stating that quality drives profit. Thereby, the society will see that they are actively trying to improve their quality, which should limit any discontent, while employees are pleased that their feedback has been incorporated into the MCS.

In the modern society, it is not enough for a large company to sell products or services and generate profit (Brunsson, 1994). It must also demonstrate that it is creating and supporting values widely held to be decent, just, rational, effective and modern, to uphold its legitimacy (Thomas et al., 1987). Therefore, many companies have become great producers of ideology as they put a lot of effort into proclaiming their positive qualities, e.g. that they are service-oriented and of great public utility. This could be readily observed in Capio. For instance, in the quality report of 2016, the business area manager proudly announced that they now report their quality metrics every month together with the financial reporting, while stressing that quality comes first. Thus, Capio Beta's leading emphasis on quality in the MCS, indicating its lead in the repair process, could potentially be explained by its extensive politicization.

From the individual employee's point of view, the room for repair was found to be greater in Capio Beta as well. In Alpha, the operative workers perceived their ability to create change to be limited and were unable to provide any example in which they had come up with a proposal which had led to an improvement in their work. One of the employees stated that any attempt to create change felt unfruitful, since there are many steps that need to be taken before something will happen. In Capio Beta, on the other hand, employees spoke positively of their opportunities to improve the system and provided several examples of situations in which they had succeeded in doing so. The operations manager explained that they had a flat hierarchy with only two levels above her and that she had been empowered to run the operation relatively freely. Thus, the operative employees could drive change by communicating with her. This difference was demonstrated through the example of the online inquiry, which had been implemented in Capio Beta as a response to the workers' call for a reduced administrative burden, but not in Alpha.

Although the framework imposed by HSN's remuneration model has given rise to similar issues in the public and private health care center's lack of repair, the interviews indicated that the individual employee in Capio Beta is provided with greater capabilities for repairing the system than those in Alpha. The underlying cause was found to be the organizational structure, and the associated feeling of being able to influence or not. According to the self-determination theory (Deci & Ryan, 2000), individuals who feel that their competence and opinions matter, develop a greater sense of autonomy. Consequently, the individual is more motivated to take initiatives and contribute with improvement proposals to shape its work environment. In Alpha, one of the employees explicitly stated that his voice was not being heard. Thus, the lack of repair could be due to its failure to incorporate the employees' feedback, which in turn leads to a lack of motivation amongst employees to contribute with any further improvement proposals.

## 5.2 Internal Transparency

Within each health care unit, dissection of budgets to relatable goals and KPIs had been done. To keep their employees updated on the status of internal processes and procedures, APT meetings as well as occupational group meetings were held. Additionally, Alpha had collegial meetings and Capio Beta had apprentice occasions. These meetings had different structures, but essentially, they were outlets for best practices to be shared as well as issues regarding

contingencies to be lifted. These efforts show that both units demonstrate similar attempts to increase the internal transparency, which indicate enabling intentions.

In practice, however, the efforts fell short in both organizations. The efforts had enhanced the employees' comprehension across both units regarding what impacts variations in their daily routines had on the outcome. Nevertheless, the operative employees showed deficient knowledge regarding the overarching processes and goals of their unit. When asked about the appropriate level of personnel, the controller of Alpha instantly referred to the operations manager. Similarly, the assistant nurse of Capio Beta automatically referred to her manager when asked about the unit's goals. These examples indicate a tunnel vision amongst employees in both health care centers, as they focus on their own practices while disregarding other processes in their units.

The NPM paradigm has directed accountability and scrutiny towards public employees. As a consequence, financial expertise in areas connected to MCS has been hybridized with medical expertise (Kurunmäki, 2004). The effect of the hybridization process was highly prevalent in both organizations, as operations managers with no background in accounting were expected to attain financial expertise. With this newly acquired knowledge, they were given the responsibility to inform their operative employees regarding the MCS. Business methods, which previously characterized private firms, were increasingly being adopted by public organizations. These methods included the dissection of budgets into relatable KPIs. By informing the employees of how their actions relate to the outcome, employees could now be held accountable through MCS. This adoption by public organizations may explain why the efforts to increase the internal transparency are similar in both organizations.

As explained by the Capio Beta's controller, it is a challenge for the operations manager to take on the responsibilities to both educate themselves and then others without a background in accounting. According to him, this makes the operations managers feel vulnerable when communicating budget related topics in which they are not proficient themselves. Further, he explained that this may be a contributing factor to why the information was not successfully communicated to all the employees. Thus, the hybridization may carry explanatory value as to why some of the efforts made by both organizations fell short in their attempts to increase the internal transparency.

### 5.3 Global Transparency

By observing each unit and the efforts made to expand the employees' understanding of their organization's broader system, three distinct similarities are identified. Firstly, each organization used benchmarking with an informative purpose. Secondly, both units belong to organizations who hold occupational group meetings. Lastly, it was revealed that despite these efforts, the operative employees across both units showed a lack of knowledge regarding the relationship between their own unit and the purchaser HSN.

In the midst of the competitive landscape induced by the free healthcare choice, Capio showed clearer signs of cooperation between its units. Hence, Capio was able to coordinate additional initiatives to enhance global transparency, e.g. Pulsen where employees could share information and spread best practices continuously, and Capio Academy where employees with certain expertise held lectures for those interested. Moreover, each newly employed individual was offered a mentorship with an operations manager from another unit, with the aim of broadening the employee's perspective beyond its own unit. Similar efforts were not identified in SLSO, which indicates that Capio's attempts to enhance the global transparency were greater.

Following the NPM reforms, the emphasis on agency performance and stakeholder interest which holds public employees under scrutiny has inspired administrative practitioners to implement benchmarking as an assessment tool. This increases the public organizations' transparency and allows them to learn from other benchmarked organizations. Thus, the reason why both organizations use benchmarking in a similar manner can be traced to the process in which public organizations adopt tools commonly used in private ones (Kouzmin, 1999).

SLSO states on their website that they continuously work to increase cooperation and information sharing amongst its organizational units (SLSO, n.d.). Capio expresses a similar interest in its annual accounts. Thus, both organization demonstrate their understanding of the value of global transparency, where occupational group meetings are one of the tools used by both units to enhance the information sharing and cooperation. In practice, however, Capio's initiatives go far beyond those of SLSO. A clear pattern was identified during the interview process, where Capio Beta showed more willingness to cooperate and to help other Capio units, whereas Alpha's assistant operations manager stated that there is internal competition within

SLSO as they compete for listed patients. A more cooperative culture leads to a higher degree of information sharing according to Mesmer-Magnus and DeChurch (2009), which may explain why Capio Beta made greater efforts than Alpha in enhancing its global transparency.

## 5.4 Flexibility

Rules and standards were mainly seen as supportive, rather than constraining, in the daily work of operative employees in both Alpha and Capio Beta. They shared the perception of being able to use their own discretion in the meeting with patients and could thus deviate from standard procedures. In practice, however, deviations from standard procedures were less common in Alpha. An unexpected event during a patient's visit was typically handled by booking a new meeting instead of dealing with the issue directly, which indicates that the worker's flexibility when dealing with contingencies is limited in practice.

Moreover, the degree to which employees were able to use their discretion in conforming to the MCS turned out to be greater in Capio Beta. An example which highlighted this difference was the use of Picsara, a new technology, which enabled its employees to conform to the control system according to their own preferences. In Alpha, one of the employees had come up with the same idea in an attempt to improve the current work process. However, he did not proceed with the improvement proposal to the operations manager as he did not believe that his idea would be put into fruition.

In addition, the local controller could use his own discretion when evaluating the performance of Capio Beta, as he followed separate metrics which were specific to the circumstances in the county of Stockholm. This discretion had created different aggregations of information, which in turn formed differing yet interrelated mental maps of Capio Beta's operation. Such enabling tendencies could not be found in Alpha, either as a result of missing data or due to its absence, which makes an insightful comparison in this aspect unfeasible.

The empirical results show that workers in Alpha are often unable to flexibly deal with contingencies, such as patients' medical issues that are more demanding than expected, as this would imply a deviation from the target number of visits built into the schedule. This could indicate a greater focus on quantitative measures in Alpha, as they put a great deal of effort on upholding their efficiency parameters in the MCS. In Capio Beta, on the other hand, more

emphasis is put on qualitative measures which can be explained by its extensive politicization. As discussed under section 5.1, the politicization of Capio Beta has resulted in a shift from quantitative measures to more qualitative ones, along with a large production of ideology. With support from the study of Konkurrensverket (2014), the superior flexibility of Capio Beta, in the face of contingencies, could thus be related to its leading focus on quality.

The deficient repair of Alpha turned out to have spillover effects on its flexibility. In Capio Beta, the use of Picsara represented an alternative method of conforming to the policies and directives regarding the administrative work. In Alpha, however, the employee who had the idea of implementing the new technology did not proceed with his suggestion to the operations manager due to the feeling of not being heard. In line with the self-determination theory, employees who feel that their competence and opinions matter in the organization are more likely to motivate themselves to contribute with improvement proposals and shape their work environment. As Alpha failed to provide its employees with a sufficient degree of autonomy and thereby motivation, the result was the absence of improvement proposals which in this case limited the employees' room for flexibility when conforming to the MCS.

## 6. Conclusions

While there is a broad range of existing research which explores the differences and similarities of MCS in public and private organizations, our literature review suggests that the individual's role in the MCS has not been fully captured. In an attempt to make a contribution to the limited research within this field, and fill the identified gap, we formulated a research question based on the notions of enabling and coercive control (Adler & Borys 1996; Ahren & Chapman 2004).

In line with the NPM paradigm and the hybridization (Hood 1995; Kurunmäki 2004), we expected the MCS of public and private health care centers to be similar. Indeed, our study did identify converging movements in line with previous research. However, the empirical findings also revealed numerous differences on the individual employee's level. In fact, enabling control was used to a greater extent in the private health care center.

Our study suggests that the public and private organization made similar efforts to enhance internal transparency and were equally successful in doing so. However, the private health care center provided better capabilities for its employees to utilize the information and thereby enable them to repair the system. Nevertheless, both health care centers were subject to the same constraints imposed by the remuneration model of HSN, whose rigid conditions provoked similar issues related to the controllability principle.

In line with Mesmer-Magnus & DeChurch (2009), we found that the cooperative environment in Capio Beta created room for increased efforts in terms of information sharing, and thus a greater global transparency than Alpha. Additionally, both organizations used benchmarking for informative purposes, a consequence of the NPM paradigm. Furthermore, the lack of repair in Alpha turned out to have a negative impact on its flexibility, as a limited number of improvement proposals from the employees resulted in the absence of alternative ways of conforming to the MCS. Thus, the general conclusion is that individuals in Capio Beta had a greater degree of flexibility.

## 6.1 Suggestions for Future Research

Unexplored topics and limitations in our study have given rise to three suggestions for future research. Firstly, one could replicate the study in other county councils, since the remuneration for the number of visits still represents a significant percentage of a health care center's total revenue in SLL, unlike other county councils in the rest of the country. Secondly, during the course of our study, a recurring theme was the constraints imposed by HSN which limited the health care center's ability to adapt its MCS to local circumstances. This invites future research to explore whether or not HSN considers these issues when forming the conditions in the contract, by conducting a study from their point of view. Thirdly, during the interview process, one of the most striking topics that was brought up was the issue of goal congruence. Two of the interviewees mentioned that the true challenge was not to decide appropriate KPIs, but rather to determine goals that all employees could agree on. They claimed that the current goals have been set with the aim to limit health care costs while selling as many visits as possible, at the expense of quality. This is in conflict with the beliefs of the medical professionals, which is to provide the best quality care regardless of the price tag. Thus, we encourage future researchers to examine whether the perception of goal incongruence is more widespread in the health care industry or not.



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## 8. Appendix

### 8.1 Appendix 1: Table 1. Interview Sample Details

Organization	Occupation	Date of interview
<b>Alpha</b>	Local controller	26/03/2018
<b>Alpha</b>	Head of controllers	11/04/2018
<b>Alpha</b>	Assistant operations manager	11/04/2018
<b>Alpha</b>	Doctor	13/04/2018
<b>Alpha</b>	Nurse	13/04/2018
<b>Beta</b>	Local controller	12/04/2018
<b>Beta</b>	Operations manager	16/04/2018
<b>Beta</b>	Doctor	16/04/2018
<b>Beta</b>	Assistant nurse	16/04/2018
<b>Beta</b>	Nurse	16/04/2018

### 8.2 Appendix 2: The Interview Guide

#### *Introduction for all Interviews*

- Ask about anonymity
- Ask about possibility to record the interview digitally
- Ask about their role in the organization and main responsibilities

#### *Questions for Controllers*

1. Could you describe your MCS?
2. What measures have been set up by you? Which measures have been set up by the top management?

3. What happens if you do not meet the targets?
4. If you were to form the budget yourself, would the measures used be different?
5. Could you please describe the frameworks set up by SLL/Capio's top management?
6. Could you elaborate on how the purchaser-provider model affects your MCS?
7. Is it possible to create change in the MCS from both your part and the employees?
8. What have you done to support and facilitate the operative employees' understanding of the measures?
9. Could you please walk us through the budget process?
10. How do you share information within SLSO/Capio? E.g. best practices?

*Questions for Operations Manager/Assistant Operations Manager*

1. Which goals and measures have been set up for your health care center, and by who?
2. What do you think of the measures?
3. What happens if you do not meet the targets?
4. Could you please describe the frameworks set up by SLL/Capio's top management?
5. Which goals and measures would you prefer?
6. Could you please describe your feedback system?
7. How do you deal with unexpected events?
8. How may the employees use their own discretion in their daily work?
9. How do you learn from experiences within your own health care center?
10. How do you share information within SLSO/Capio? E.g. best practices?

*Questions for Operative Employees*

1. How may you use your own discretion in your daily work?
2. How do you improve current work processes?
3. How do you learn from experiences within your own health care center?
4. How do you share information within SLSO/Capio? E.g. best practices?
5. Which goals and measures have been set up for your health care center, and by who?
6. What do you think of the measures?
7. Could you please describe your unit's relationship to HSN?
8. How do variations in your daily work relate to deviations between the budget and the outcome?
9. How can you affect the design of the budget?
10. Are you interested in learning more about the financial aspects of your operations?