

Two Worlds Colliding: Exploring the Influence of Conflicting Logics on Performance Measurement Systems in Private Healthcare

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Abstract

This paper examines the emergence of conflicts regarding Performance Measurement Systems (PMS) in complex institutional settings. While the existing literature has primarily focused on the influence of institutional logics on PMS design at the field and organizational level, our study shifts attention to the employees in charge of daily operations. Through a single-case study on a privately owned healthcare unit we explore how individuals and groups perceive the degree of compatibility between logics differently, and subsequently, how this affects the perception and effectiveness of the system. By focusing on employee reaction towards top-down enforced metrics that contradict their values and beliefs, we aim to advance the current body of literature. Our study takes the existence of stakeholder influence, conflicting logics, and embedded values within metrics as a starting point and directly examines how and why tensions regarding PMS in complex institutional settings arise, and in turn, how individuals within these organizations respond. Drawing on eight in-depth interviews, we find that certain metrics are more prone to intra-organizational conflicts and may cause emotional reactions among employees, influencing their perception of the organization.

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Keywords: Performance Measurement Systems (PMS), Institutional Logics, Institutional Complexity, Coercive PMS, Compatibility

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1 Introduction

Few sectors hold a societal position as unique as healthcare. Its occupational group of medical professionals are celebrated for their passion and dedication in caring for others, but are still residing within a world of limited financial resources. The question is: How do you balance business considerations with great compassion for patients?

This is a qualitative single case study examining the emergence of value-based conflicts regarding performance measurement systems, conducted in the interesting setting of healthcare, a sector exposed to strong stakeholders incorporating multiple institutional logics.

Existing literature in the area reveals that stakeholders' institutional logics significantly influence the design, implementation and use of PMS, consequently embedding metrics with various values and beliefs (Chenhall et al., 2017; Kurunmäki, 2004; Pache & Santos, 2013). These underlying values within PMS can create conflicts between organizational actors adhering to different logics (Bedford et al., 2019; Morinière & Georgescu, 2022). Therefore, PMS provides a natural arena for debate between stakeholders with conflicting values, each aiming to influence the organization according to their priorities and interests (Brignall and Modell, 2000).

The focus of previous research concerning PMS in institutional complexity¹, has either been on the field-, external stakeholder-, or organizational level (Greenwood et al., 2011; Reay & Hinings, 2009; Carlsson-Wall, Kraus & Messener, 2016; Chenhall et al., 2013; Pache & Santos, 2013). Hence, the individual and operational perspective remains underexplored, and is currently requested by researchers in the field (Greenwood et al., 2011; Chenhall et al., 2017; Reay & Hinings, 2009; Battilana & Dorado, 2010). While it is recognized that tensions due to logics in PMS naturally create obstacles that can lead to the formation of coalitions, the specific way these tensions manifest among individuals with different logics is yet to be understood. Particularly when metrics are perceived as coercive and top-down enforced throughout an organization (Adler & Borys, 1996; Wouters & Wilderom, 2008; Jordan & Messner, 2012). Our study addresses this called for gap by answering the following research question:

¹*Institutional complexity* is the definition of organizations that incorporate more than one institutional logic (Pache and Santos, 2013; Greenwood et al., 2011).

How and why do tensions regarding performance measurement systems arise in complex institutional settings, and how do individuals within these organizations react to them?

This research question is crucial for several reasons. To begin with, comprehending how and why resistance to PMS may arise can facilitate the understanding of how to proactively mitigate conflicts within organizations and ease collaboration among individuals or groups adhering to different values and beliefs. In turn, this increases awareness of how to overcome logic-based barriers, ultimately improving overall organizational performance. Moreover, this understanding will deepen our knowledge of the expressive role of PMS, advancing the discussion on how PMS aid or impede the alignment of organizational objectives (Chenhall et al., 2017).

Furthermore, understanding how individuals on the operational level react when PMS are implemented is essential, as it provides insights into the consequences of conflicts on the system's effectiveness. As PMS is ultimately enacted at the operational level, it is here – not in management or through interactions with external stakeholders – that the success of PMS can truly be assessed. Since operational employees have the direct power to influence how PMS is utilized in the daily operations, there is great need for further insight into their perspective as they are essential in ensuring the desired implementation.

In addition, by examining top-down enforcement and perceived coerciveness of metrics, we shed light on how power dynamics affect organizational actors' perception and reaction. This demonstrates how the relative influence of different stakeholders affects the use of PMS and contributes to the understanding of how organizations can foster greater compatibility among actors. Our finding has significant practical implications for mitigating conflict and aligning objectives effectively.

The aim of our study is to explore emotions, personal reactions, and experiences related to the PMS within organizations. To achieve this, we have adopted a qualitative single case study methodology that enables a comprehensive examination of the social and cultural contexts of PMS and institutional logics. Case studies are particularly well-suited when describing accounting systems, techniques and procedures used in practice, aligning with our objective (Ryan et al., 2002).

The organization examined for this study, referred to as *CareCompany*, is a privately owned healthcare unit chosen for its anticipated rich institutional complexity. Healthcare has

previously been shown to embody multiple institutional logics due to its diverse set of stakeholders and important societal position (Brignall & Modell, 2000; Reay & Hinings, 2009; Kurunmäki, 2004; Morinière & Georgescu, 2022). However, in contrast to previous studies, CareCompany is not governed by the state but instead owned by a private equity firm, called *CapitalPartners*. This ownership structure incorporates an inherent duality in organizational priority between maximizing profit and delivering the best possible care to patients, which is limited financially by fixed compensation rates. The setting is optimal for exploring how PMS interact with divergent values and, in turn, cause reactions among organizational members.

In total, eight in-depth semi-structured interviews were conducted with a diverse group of participants at CareCompany, including physicians, physiotherapists, unit managers, senior managers, and other representatives. Interview guides were utilized to efficiently steer the conversations into the general topics of interest but allowed for flexibility in both responses and follow-up questions. This approach allowed us to capture a wide range of perspectives and account for hierarchical discrepancies. Effectively, creating a strong empirical foundation.

Our findings reveal that metrics implemented by a single stakeholder and embedded with one strong and distinct logic, are more prone to causing intra-organisational conflict. This is evident as the financial and productivity metrics backed by CapitalPartners are creating recurring tensions on how to balance *profitability* with optimal *patient quality care*². This discussion is anchored in the presence of two dominant logics, influencing individuals' stance in the debate. On the one hand, we have the *business logic* which emphasizes profitability, cost-efficiency, and productivity, thus clearly backing the financial metrics. On the other hand, we have the *medical professionalism logic*, which prioritizes patient safety, quality, engagement, and professional autonomy, strongly advocated for by the workforce.

Moreover, individuals and groups within the organization perceive the compatibility between these two logics differently. We observe that the more rigidly a group or individual adheres to a single logic, the more likely they are to perceive metrics rooted in the opposite logic as infringing on their personal values and beliefs. At CareCompany, it becomes apparent that operational employees are strongly committed to medical professionalism, which causes an emotional reaction when financial metrics are coercively enforced. The finding is further

² We refer to *patient quality care* as a term for professional autonomy and outstanding care quality beyond the minimum standard dictated by the patient safety, which may be continuously improved.

complicated by the presence of high visibility of power, meaning that the increasing financial focus is perceived by employees as a result of pressure from the owners. This causes some employees to not only emotionally react but also distance themselves from the underlying stakeholder of the top-down enforced metrics, CapitalPartners.

In short, our contributions bridge the research gap by extending the discussion within three areas of literature. Firstly, we delve into the literature on institutional logics, suggesting that perceived compatibility between logics manifests not only at the field and organizational level but also at the individual level. Secondly, we address PMS within the context of institutional complexity, by incorporating both the individual and intra-organizational perspectives on logic-based conflicts. We suggest that the stronger the adherence to distinct logics among groups or individuals within an organization, the higher the probability of conflicts concerning PMS emerging. Furthermore, the level of commitment to a specific logic significantly affects the degree of emotional reactions and resistance to metrics rooted in a conflicting logic. Thirdly, we explore the domain of performance measurement systems, focusing on its coercive and expressive role. Our findings suggest that perceived coerciveness, visibility of power, and embedded values within PMS at the operational level may have the negative consequences of stakeholder decoupling.

2 Literature Review

The theoretical background is structured into two main sections. First, we will introduce the theoretical lens of institutional logics to better understand the role of performance measurement systems in an institutionally complex setting. Second, we will examine the current literature on how PMS function within this context and investigate strategies for addressing potential conflicts among stakeholders seeking to influence its design, use, and implementation. Lastly, we will discuss the existing gaps within the field.

2.1 Institutional Logics and Institutional Complexity

Organizations must take into account the diverse values and expectations of their stakeholders in order to sustain collaboration. According to institutional theory, these varying demands can be conceptualized as 'institutional logics' (Thornton et al., 2012), defined as *the socially*

constructed, historical patterns of cultural symbols and material practices, including assumptions, values, and beliefs, by which individuals and organizations provide meaning to their daily activity, organize time and space, and reproduce their lives and experiences (Thornton & Ocasio 2008). In simpler terms institutional logics is the embedded cultural aspect within a field, organization, occupational group or individual which make up the taken for granted thoughts concerning what goals are legitimate and in what manner they should be pursued (Reay & Hinings, 2009; Pache & Santos, 2013). In this paper, we will use 'institutional logics' as the overarching term to frame our discussion concerning underlying values and beliefs, and its effect on PMS at the group- and individual levels.

Organizations that incorporate more than one institutional logic, have an embedded challenge to combine the demands from different stakeholders, and are defined as *hybrid organizations* (Battilana & Dorado, 2010; Pache & Santos, 2013). Hybrid organizations thus face institutional complexity and must navigate the diverse expectations they are exposed to (Pache & Santos, 2013; Greenwood et al., 2011). An example of this is the privatization of the public sector in the 1970s, driven by the New Public Management (NPM) movement. This transformation introduced ambiguity between the business logic of efficiency, productivity, and profit and the previously dominant healthcare logic, which valued patient needs. The privatization blurred traditional boundaries, creating a complex landscape where the principles of both business and healthcare had to try and coexist (Brignall & Modell, 2000; Kurunmäki, 2004; Thomasson, 2009; Reay & Hinings, 2009).

Research suggests that organizations facing multiple institutional logics may either experience them to be in conflict, harmony or in a more complex ambiguous relationship (Chenhall et al., 2013; Pache & Santos, 2013; Carlsson-Wall, Kraus & Messener, 2016). If the cause-effect relationship between logics is ambiguous it allows the possibility for different ways of enacting logics, not only between organizations and fields, but also depending on the situation at hand (Carlsson-Wall, Kraus & Messener, 2016). However, organizations characterized by institutional complexity have shown to be more prone to internal conflicts, and groups representing different logics may emerge (Pache & Santos, 2010; Battilana & Dorado, 2010). These groups may clash, each striving to assert their preferred values and logics (Glynn, 2000). Such conflicts are particularly apparent in organizations facing long-term institutional pluralism, which heightens the need of balancing competing logics on a permanent rather than temporary basis (Pache & Santos 2013). Moreover, logics in conflict naturally create

obstacles and strains for the organizations subject to them, and as the degree of incompatibility between logics increases, so too does the difficulty of balancing the expectations of all stakeholders (Greenwood et al. 2011). Early studies viewed these conflicts as transitional or temporary with one logic eventually emerging as dominant, thus largely overlooking the ongoing complexity of such conflicts. Recent research, however, has emphasized that multiple logics can coexist for extended periods within an organization, suggesting a more enduring and intricate interplay than previously acknowledged (Reay & Hinings, 2009). Taken together, these insights suggest that hybrid organizations may need to mobilize different response strategies to cope with internal conflict, depending on whether they are exposed to conflicting demands related to goals or means (Pache & Santos, 2010).

2.2 Performance Measurement Systems

2.2.1 Coercive and Enabling Performance Measurement Systems

Performance Measurement Systems are adopted by organizations with the purpose to *convey*, *assist* and *support* organizational objectives and growth by employing specific measurements, targets, and rewards (Ferreira & Otley, 2009). The implementation of PMS means establishing a form of control or formalization, which can be categorized as either *coercive* or *enabling*. Coercive formalization refers to PMS that cater to the needs of higher management and primarily aims to control employees' behavior into compliance, whereas enabling formalization describes systems that assist employees in improving their work by providing feedback, identifying issues and uncovering opportunities for improvement (Wouters & Wilderom, 2008). Adler and Borys (1996), creators of the framework, suggest that employees' reactions and attitude towards formalization depends on its nature. They propose that attitudes are more favorable when formalization is perceived as enabling, and less favorable when it is seen as coercive. Moreover, recent literature adds to this by suggesting that it is when evaluation pressures significantly increase, and flexibility³ concerning metrics is diminished, that the PMS is increasingly perceived as coercive, causing some to distance themselves from the measurements (Jordan & Messner, 2012). These negative effects have shown to be mitigated when stakeholders are involved in the design and development process of the control system, during which metrics can be experimented with before implementation (Wouters & Wilderom, 2008). Furthermore, the impact of transparency and visibility within

³ Defined by Jordan, S, & Messner (2012) as the “relative importance given to the selected output indicators as compared to other concerns”

these systems is ambivalent. On one hand, it can aid employees' understanding of the system's underlying rationale, potentially increasing acceptance. On the other hand, it may lead to employees more easily questioning the system (Jordan & Messner, 2012).

2.2.2 Performance Measurement Systems in Institutional Complexity

The central role of PMS draws attention from various stakeholders (Atkinson et al., 1997; Sundin et al., 2010), which increases the need for management and integration of diverse stakeholders' institutional logics. It acts as a bridge, connecting the organization's strategic objectives with its priorities and values. Hence, PMS also provides an important arena for incompatible logics (Chenhall et al. 2013; Carlsson-Wall, Kraus & Messner 2016; Brignall & Modell, 2000; Morinière & Georgescu 2022) and provides a natural stage for power struggles among stakeholders with conflicting priorities, each aiming to influence the organization according to their interests (Brignall & Modell, 2000). Various groups within the organization have more or less relative power. As a result, organizational responses to multiple institutional logics are likely to be reflective of the interests of the group with the most influence. In this way, appreciation and recognition of logics, and the choice of which logic to prioritize and how to do so, will be dictated by those with the most power (Greenwood et al. 2011). This closely connects PMS and institutional logics to the power dynamics of an organization. PMS is thus *not* a neutral ground for measurements, targets and rewards but instead a carrier of underlying values and agendas reflecting the stakeholders logics, and embodying an expressive role (Chenhall et al. 2017).

Prior papers discuss how the value-based role of PMS influences its *design, implementation* and *use* and, in turn, how the organization utilizes PMS to satisfy expectations of key stakeholders (Atkinson et al., 1997; Pache & Santos, 2013; Chenhall et al. 2013; Chenhall et al. 2017; Sundin et al., 2010; Kurunmäki 2004; Dent 1991; Carlsson-Wall, Kraus & Messner 2016; Morinière & Georgescu 2022). Our study builds upon the literature by adopting the starting point that PMS are chosen with a specific purpose and embody certain values reflecting the priorities of the organization and its influential stakeholders. The underlying values, stemming from the logics, may either align, conflict, or relate ambiguously to stakeholders beliefs. As a consequence, PMS can cause conflicts within organizations due to the implicit ethical stance embedded in their design and implementation. This divergence can

generate friction among individuals and groups, reflecting their varied values and logics (Bedford et al., 2019; Chenhall et al., 2017; Pache & Santos, 2010).

2.2.3 Strategies for Incompatible Logics in Performance Measurement Systems

In the case of conflicting institutional logics between stakeholders there are three prominent coping strategies related to PMS: *decoupling*, *structural differentiation* and *compromise* (Pache & Santos 2013; Brignall & Modell, 2000). *Decoupling* is when organizations symbolically endorse practices prompted by one logic or stakeholder while implementing those advocated by another. This results in a gap between symbolically adopted policies and actual organizational behavior (Brignall & Modell, 2000). Furthermore, *structural differentiation* refers to dividing the organization into distinct subunits, each oriented towards different institutional logics. Lastly, *compromise* involves finding a middle ground that partially satisfies the expectations of various parties. For instance, health care organizations might balance the demands of medical care quality and fiscal efficiency by adhering to minimum standards that secure both professional and political support (Pache & Santos, 2013). Chenhall et al. (2013) further develops the compromising strategy by proposing that the design of PMS can serve as 'compromising accounts,' facilitating productive debate among differing logics. This productive debate hinges on three critical elements. The first is *imperfection*, which assesses how effectively the PMS balances various institutional logics, embodying a dynamic 'give and take' approach. The second is *concurrent visibility*, which involves making the attributes of different logics transparent within the design of the accounting practices, and the third is ensuring that discussions focus on *underlying principles* rather than technical details.

2.3 Gaps in the Existing Literature

Our study concurs with the aforementioned literature but aims to contribute by addressing the underexplored area of the individual and operational perspective. The focus is not on the design of PMS or on management- or external stakeholder levels as previous literature, but rather on the operational level's *reaction* to top-down enforced PMS and how and why conflicts concerning metrics may arise through the theoretical lens of institutional logics. Thus, our research addresses a called for gap by preceding researchers (Greenwood et al., 2011; Chenhall et al., 2017; Reay & Hinings, 2009; Battilana & Dorado, 2010).

3 Methodology

In the following section, we will outline our research design, data collection, and data analysis processes. This includes detailed information about our choice of case company and our approach to conducting the research. Additionally, we will describe the methodologies used and provide a comprehensive view of how the data was gathered and interpreted.

3.1 Research Design

Our research adopts a qualitative single case study approach to investigate *how and why tensions regarding performance measurement systems arise in complex institutional settings, and how individuals within these organizations react to them*. Our thesis contributes to the called-for area of qualitative research within the field of accounting (Lee & Humphrey, 2006; Power & Gendron, 2015) by conducting an in-depth case study, primarily through semi-structured interviews and secondarily through data collection of documents and observations at the case company. This is a common and effective method combination in accounting research when collecting qualitative data (Lee & Humphrey, 2006).

Qualitative methods are suitable for capturing detailed, context-rich data necessary for understanding the specific historical, social, and organizational contexts in which accounting practices operate (Lee & Humphrey, 2006). Case studies, specifically, are generally used for describing accounting systems, techniques and procedures used *in practice* (Ryan et al., 2002). To answer our research question, a qualitative case-study approach is hence appropriate in order to explore emotions, perceptions, personal reactions, and experiences related to the PMS. The analysis allows us to delve deeply into the cultural and emotional nuances of the organization which is necessary to understand individuals' perceptions and reactions. The chosen method is better suited compared to a quantitative approach, which might overlook these critical aspects (Denny & Weckesser, 2022).

The chosen organization for our study is a privately-owned healthcare unit in Sweden, referred to as CareCompany. The private healthcare sector was selected as it has shown to incorporate a natural clash of institutional logics (Brignall & Modell, 2000; Reay & Hinings, 2009; Kurunmäki, 2004; Morinière & Georgescu, 2022). This setting was anticipated to

contain comprehensive PMS aimed at managing the different logics (Carlsson-Wall, Kraus & Messner 2016), an ideal setting for our investigation of PMS within institutional complexity.

The study is narrowed to focus on a single organization. As it was deemed more valuable to investigate the dynamics thoroughly at one organization, rather than pursuing a multiple case study that would compromise the in-depth analysis.

3.2 Data Collection

3.2.1 Semi-Structured Interviews

The primary method for gathering data involved conducting semi-structured interviews with various members of CareCompany, including Employees, Management, and other representatives (see Appendix 1 for details of the interviews). The data collected provided the empirical basis for analysis and contributions.

Snowball sampling was employed for the data collection, starting with the pilot interviewee suggesting two Senior Managers, one Business Controller and one Unit Manager who were subsequently contacted via email and interviewed. These were suggested based on their extensive knowledge of the existing PMS. Following, in the subsequent interviews, we expanded our participant base to other hierarchical levels, including employees directly involved with patient care to gain a more nuanced perspective of the PMS. Participants also varied in their duration of employment, which provided further diversity on the topics discussed. While aware of the potential bias inherent in snowball sampling – whereby interviewees may suggest others sharing similar views – the risk was counteracted by incorporating a broad spectrum of hierarchical standpoints (Emerson, 2015). Given that the research question emphasizes individual values, beliefs, and reactions, this also helped mitigate the risk associated with chain-referral sampling.

The interview guide was semi-structured and open-ended to encourage personal detailed responses, but still structured around themes relevant to our research (Qu & Dumay, 2011). This approach facilitated in-depth discussions while ensuring the interviews' relevance to the study's objectives. Semi-structured interviews are a common and well-suited way of collecting data for qualitative research as they offer detailed, organization-specific insights while allowing for the comparability of responses. They also enable spontaneous follow-up questions that can uncover unexpected insights and thus balance the conversation into being

open and flexible while allowing the interviewee to follow-up in angles that are deemed interesting.

Eight in-depth interviews were conducted, each lasting approximately 50 minutes (see Appendix 1). The number of interviews were deemed sufficient as we had obtained a strong empirical foundation with no new relevant information being provided by later interviews.

3.2.2 Interview Context and Technique

Out of the eight interviews, two were conducted face-to-face, while the remaining six were carried out via Microsoft Teams. All interviews were conducted in the native languages of the respondents to ensure that the authenticity and quality of the dialogue were maintained. Consistent with GDPR requirements, all participants provided their consent through a form that informed them about their confidentiality and handling of their personal data, underscoring the importance of privacy in achieving transparent responses.

The structure of the interviews followed an interview guide that outlined fundamental themes across all interviews. However, the specific questions were tailored to suit the particular hierarchical position and expertise of each interviewee (see Appendix 2 for a more detailed description of the alteration). The interview guide was generally not distributed to participants beforehand unless specifically requested. This was to stimulate more spontaneous and genuine responses. Notably, one participant did request to view the guide in advance to better prepare due to their recent hiring. We deem this did not skew the results, as the questions on personal opinions, values, and beliefs were not included in the previewed guide and thus, these responses were gained without prior preparation. Throughout the interview process, field notes were taken to capture prominent themes, which served as the basis for alteration of the interview guide for subsequent interviews.

3.2.3 Secondary Data

In our study, various sources of secondary data were utilized, including publicly accessible annual reports, website content, and informational videos released monthly to the staff. Additionally, a comprehensive tour of CareCompany's facilities was conducted to better understand the work environment. The secondary data provided a broad overview of the vision and mission of both CareCompany and HealthGroup, as well as insights into the organizational structure. The internal and external documents were primarily reviewed to gain

a deeper understanding of the company's values and structural dynamics, ensuring appropriate preparation for the interviews. For confidentiality reasons, neither the external nor the internal documents will be included in the reference list.

3. 3 Data Analysis

Data analysis was conducted continuously throughout the study with the purpose of leveraging key insights from previous interviews to refine the focus for upcoming sessions. A thematic approach was utilized to analyze the interview data, a method supported by Mattimoe et al. (2021), describing thematic analysis as a technique for “...*identifying, analyzing, and reporting patterns (themes) within data...*”. Transcription was crucial for ensuring data accuracy and for identifying themes and insights that would inform new, adjusted, interview guides. Field notes taken during these sessions supplemented and enhanced the analysis.

In total three rounds of interviews were conducted with subsequent data analysis to maintain the iterative progress. To prepare for the initial round, we conducted a pilot interview that provided valuable knowledge about the organizational structure of CareCompany and its current PMS. The interview boosted our confidence and shaped our approach for future interviews, aiming to uncover the underlying dynamics further.

The first interview guide was designed to primarily understand the organizational structure and the PMS at CareCompany. Questions were structured around targets, measurements, and rewards, but also progressively explored associated logics and tensions. During the first formal data analysis, interviews were transcribed and analyzed to identify themes that could steer the direction for the second round of interviews.

The interview guide for the second round was therefore adjusted to start with questions regarding institutional logics, as we aimed to deepen our understanding of the various conflicts present within the organization. This adjustment was helpful in yielding more descriptive responses about the interplay of tensions and the role of PMS. In the second phase of formal analysis, all interview transcriptions were combined under thematic headings to highlight commonalities across the data. This approach was crucial in narrowing down the scope of our final interviews.

The third round of interviews focused on the individuals' reactions, perception and motivations at the employee level. The final stage of analysis involved integrating all data into the compiled document, and conducting a thorough review of all materials to identify any overlooked details and to finalize our conclusions.

This methodical approach allowed us to continuously refine our understanding and incorporate new ideas as they emerged, ensuring that our analysis remained closely aligned with our theoretical framework.

4 Findings

4.1 Case Context

Since its founding in the latter half of the 20th century, CareCompany has operated as a privately owned healthcare organization in Sweden. Despite the rarity and scrutiny that privately-owned healthcare facilities faced during the time, CareCompany has maintained its prominence throughout political shifts and today remains a leading healthcare provider.

A few years ago, CareCompany was acquired by *HealthGroup*, a conglomerate fully owned by a private equity firm, referred to as *CapitalPartners*. Even though CareCompany has always been under private regime, the acquisition marks the first time that CareCompany has come under the ownership of a private equity firm. As a consequence of the acquisition, CareCompany was integrated as a part of a group below HealthGroup, referred to as *HealthCare Unit*. This structural change has led to a shift in financial governance as CareCompany no longer operates as an independent entity since its financial results are now instead consolidated and managed at the subsidiary level by HealthGroup.

At CareCompany, Senior Managers constitute the “highest” hierarchical level (see Figure 1). The Senior Managers act as the primary interface between CareCompany and HealthGroup, and vice versa. They are thus responsible for reporting CareCompany's activities to HealthGroup and for implementing their objectives throughout the organization. Next in line, and reporting to the Senior Managers, are the Unit Managers, who oversee the Employees⁴ - the first point of contact for patients. The Unit Managers thus represent the interests and

⁴ In this study, we refer to Employees as the group that works directly with patients, such as nurses, physiotherapists, physicians etc.

well-being of the Employees to the Senior Managers and administrate the daily operations for their unit.

CareCompany itself is organized into two primary divisions: *outpatient care* and *inpatient care*. At the operational level, patients are divided between the two divisions according to their healthcare needs. Outpatient care provides medical services to patients who do not require an overnight stay. In contrast, inpatient care accommodates patients requiring overnight stays, typically for more severe medical conditions. The duration of stay and specifics of patients' treatments is overseen by a diverse and collaborative team of healthcare professionals. This team typically consists of various health care professionals such as Senior Consultants⁵, physicians, assistant nurses, physiotherapists, and occupational therapists, working together to provide comprehensive care and address all health needs of the patients. Within each team, the Senior Consultant holds ultimate medical responsibility and accountability for the patients.

Patients are admitted to CareCompany based on various contracts issued by primarily three different stakeholders: the public sector (the regions), insurance companies, and private entities. Most contracts are gained through public procurement from the region, which dictates the compensation for each patient and sets specific terms for the duration of stays and the flexibility of visits. These contracts are vital to CareCompany's financial sustainability as they define the compensation per patient.

⁵ In swedish translated to "överläkare".

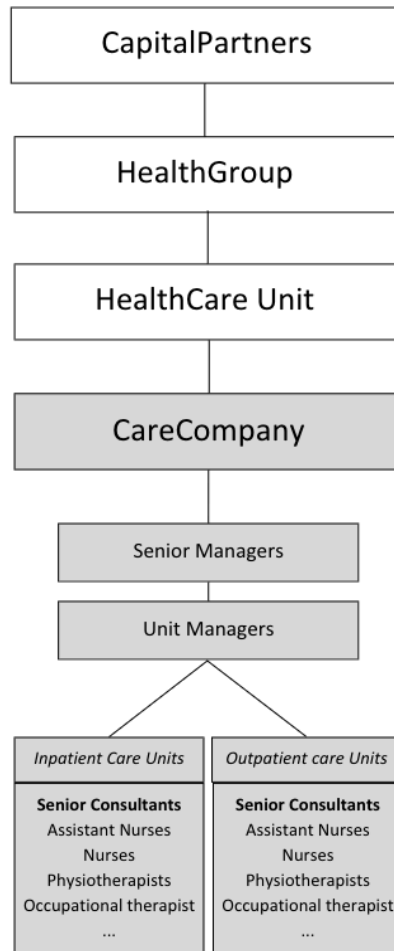


Figure 1, Simplified Organizational Chart

4.2 Performance Measurement System at CareCompany

The PMS at CareCompany is centered around three overarching focus areas: *medical quality*, *leadership & employee engagement*, and *operational & financial ability*. All which aim to align the goals and objectives throughout the organization. Furthermore, by taking stakeholder influence and their underlying values as a starting point, our study reveals that the PMS at CareCompany may naturally be divided into three other key areas based on which **stakeholder the metrics originate** from: *medical quality compliance metrics*, *internal progress metrics*, and *financial & productivity metrics*.

4.2.1 Medical Quality Compliance Metrics

The *medical quality compliance metrics*, such as the national quality index, are heavily influenced by the external issuers of the contracts under which CareCompany admits patients.

These external stakeholders regulate the medical quality throughout the health care system with the intention of withholding an accepted minimal standard across all actors in the industry. Additionally, CareCompany is subject to several different certifications which requires them to uphold a certain standard in terms of medical quality. This regulates CareCompany and HealthGroup at large, to maintain the quality and safety necessary for laws, regulations, and contracts. The work concerning medical quality compliance metrics was emphasized by an interviewee:

*“When it comes to the **medical objectives**, a lot is determined by how we are financed, namely from the Region. For example, we must participate in the quality registry and meet the required competencies, so that part is quite controlled... but then there's also the medical management responsibility where we are subject to the healthcare law and must fulfill a lot of medical requirements through legislation”*

The medical quality metrics are internally regulated and continuously monitored. Utilizing medical records and individual patient logs to oversee the alignment with the medical quality. This is to ensure the maintenance of the minimal standard of operating as a healthcare facility.

4.2.2 Internal Progress Metrics

The *internal progress metrics* originate from CareCompany itself, and sometimes in conjunction with HealthGroup. The underlying purpose of these metrics is to surpass the basic requirements set by medical quality compliance regulations, thereby fostering professional excellence through close monitoring of both employees and patients. These metrics include patient satisfaction, employee satisfaction, patient culture index, medical deviations, among others. The outcome of these targets are shared with employees and evaluated by Senior Managers and Unit Managers on a monthly basis.

4.2.3 Financial and Productivity Metrics

The *financial and productivity metrics* are implemented in order to assure compliance with the set budget. Key metrics include the *occupancy rate* of patient beds, the *average length of patient stays*, *average price per patient*, and *labor expenditure*, all of which aim to monitor CareCompany's profitability and productivity. The benchmark and targets are set annually by CapitalPartners and HealthGroup during the budgeting process, and enforced top-down. The approach is highly hierarchical as described by an interviewee:

“One could say that the process is really top-down. HealthGroup wants a certain margin, and different units get different margin targets. These are determined from the very top, that is, by the management and the owners, how they want it to be...Senior Managers are then involved in the budget process within the existing framework of influence”

Senior Managers of CareCompany receive the budget from the management of HealthGroup. The metrics and guidelines are then broken down into smaller components and distributed throughout the organization. As described by a Business Controller:

“HealthGroup's guiding principles are the foundation of what we do as part of the larger organization. And everything we do at HealthGroup should eventually trickle down to the level of the Nursing Assistant. It is the managers' mission to ensure that goals are set that can be broken down at the unit level so that it fits everyone. Because if there is a big vision or a big goal for HealthGroup, it might be difficult for a Nursing Assistant to relate to it.”

Furthermore, it is clear from the interviews that the financial metrics are heavily pursued throughout all hierarchical levels of the organization:

“There is a lot of pressure on Managers in general. They hold responsibility for many employees, they need to optimize operations and so on. But above all, there is a very high financial pressure from above. I mean, there is high pressure on production as well, and I don't think it was as high before the acquisition. But of course, the business must be viable. There's nothing strange about that.”

Other interviewees also agree that since the acquisition by CapitalPartners, there has been an increased focus on financial and productivity metrics:

"After the acquisition, it's tougher. It's significantly tougher. It's more control-driven. That's how it is... But generally, you could say this: if you're owned by a venture capitalist, then it's definitely tougher, right? It definitely is... This organization is probably more top-down than organizations that I have worked in before."

This suggests a perception that the financial metrics have become more coercive in their formalization. Furthermore, the metrics are continuously evaluated on a weekly and monthly basis and reported to Senior Managers as well as the management of HealthGroup.

4.3 Tensions within Financial and Productivity Metrics

Although all categories of metrics are expressed as important for CareCompany's operations it is evident from the interviews that the financial and productivity measurements gain significant internal attention. This conclusion can be drawn, as almost all respondents, except one, began their answer to the interview's opening question, "What goals and metrics do you have in the organization?" by discussing financial metrics in detail. Additionally, when interviewees were asked which metrics were the most emphasized within the organization, several highlighted the financial ones:

"Yes, there are plenty of metrics, but the most important one that we're working with right now is the average length of patient stays and the occupancy rate."

This observation is further reinforced by the fact that the interviewees often had more difficulty articulating the non-financial metrics within the organization. The observation does not imply that these metrics are unimportant or neglected; rather, it suggests that they do not attract the same internal focus.

4.3.1 Institutional Logics as a Source for Tensions

The underlying logic behind the financial and productivity metrics mentioned above, is that of **business**, stemming from the owners primary mission of securing profit. This may create issues within the organization, as it is not necessarily the primary objective of the Employees responsible for the patients:

*"Of course, I have a different goal than the owner of HealthGroup. I mean, my goal is to do a good job for the patients. Their job is to get a return on their money. **And that's two different goals.** You can't escape from that, even though I fully understand their side."*

As Employees' primary focus is patient care rather than the profitability of the company, some express disinterest or resistance towards financial objectives. The strain originates from the presence of another strong logic which is rooted in a different set of underlying values than the business logic, the *medical professionalism*. Medical professionalism values professional autonomy, patient care, and quality which is also strongly correlated with the professionals' motivation for entering the medical field. As highlighted by several interviewees:

“The most important thing is that I have time for my patients. Then, of course, it's also nice to have friendly colleagues and so on. But above all, it's the work with the patients and having the time I need to do a good job that motivates me.”

“What drives me is my patient engagement. It's fun with coworkers, but that's not what motivates me”

From the perspective of institutional logics, the balance between *business* and *patient quality care* have natural tensions within healthcare, as highlighted in previous literature (Brignall & Modell, 2000; Reay & Hinings, 2009; Kurunmäki, 2004; Morinière & Georgescu, 2022). Similarly, at CareCompany there is a continuous struggle for coexistence between the two deeply embedded logics. In this balancing act, the PMS serves as an arena for debate of incompatible logics, where the business logic (backing the financial metrics) and the medical professionalism (advocated for by the whole workforce), may collide.

4.3.2 The Conflicting Situation

The conflict demonstrates a situational dependency, as the logics of business and medical professionalism coexist without causing resistance in most instances at CareCompany. For example, there is no risk of situations arising where *patient safety*⁶ is compromised as all stakeholders prioritize this above all financial considerations. This is confirmed by several interviewees:

“There are several different focus areas of metrics’, but the economy is always a strong one. A very strong priority. At the same time, as we work within healthcare, patient safety is what stands foremost. If there is something that we need to prioritize there, then we must set aside the economics. Patient safety always comes first, absolutely. Otherwise, we cannot be responsible. It's not possible.”

“I have never found myself in a situation where safety is not the highest priority. I can say that.”

⁶ Patient safety is defined as the essential care needed in order to meet the medical standards mandated by the state and to function as a healthcare company.

Instead, the situation that causes conflict is concerning *patient quality care* which in contrast, is more subjective than patient safety as it might be continuously improved. Therefore, discussions may arise regarding what level of patient quality care constitutes “good enough” in relation to the financial targets, such as occupancy rate and average patient stay. This highlights the difficulty of enforcing financial metrics without infringing on the medical professionalism values. For example, as Employees aspire to deliver exceptional patient quality care, they may prefer to admit fewer patients and extend certain treatments longer than what might be deemed reasonable from a business perspective. This misalignment is exacerbated by the subjective nature of quality and its ambiguous cause-effect relationship with business considerations, and thus result in the tensions illustrated by the quotes from a manager and an employee below:

“The tension arises because Employees may not feel that they can give their full capacity. It's hard to reconcile this with the business aspect. So it's a tough nut to crack, this is about Employees needing to understand that they are actually part of a company.”

“Lately, there is an increasing focus on that we need to bring in money, and perhaps those of us in healthcare don't like to talk about that part as much. It's also partly why we chose this profession, as we only want to think about the patient and the quality. But we still have to work as we are told of course.”

The aforementioned disagreement has significant empirical importance, as it is described by every interviewee. This situational tension will be the exclusive focus of the following sections, exploring how and why it manifests, and examining its impact on individuals at CareCompany.

4.4 Group Coalitions

The situation of conflict at CareCompany creates internal debate, and groups representing different logics emerge. These coalitions are divided between those who view the underlying values of medical professionalism and business as compatible, and those who see them primarily as conflicting. Although there is individual variation, a pattern has emerged where those in managerial positions often seem to take a more compatible view than Employees, who perceive them as opposing. To fully understand the underlying mechanisms and logics shaping each side's reaction towards the financial metrics, both perspectives will be presented below.

4.4.1 Managers Perspective

As previously mentioned, Managers (Senior Managers and Unit Managers) at CareCompany are accountable for pursuing financial targets set by HealthGroup. Following, a manager describes the institutional pressure associated with the role:

“We have quite demanding managers from HealthGroup. They are really great, but they have high expectations, so high that at times, I even think they might not be reasonable. They set the bar this high (refers to a certain height) so that we can reach this level (points below the level aimed for). But they are very knowledgeable and interested, so it's not like the goals and figures that are set just fade away and you can do as you please; you know that they are followed up on. And it is primarily financial goals that they pursue, so we have quite strict monthly reviews of our economy to see exactly how things are going.”

The Managers view the financial outcome as a part of their responsibility, and strive to understand the business logic advocated by the owners and top managers of HealthGroup. The fact that the organization focuses on financial targets is not seen as negative or unusual by the Managers, who state that they understand the implications of operating as a privately owned facility and the essence of its business, even as financial pressures intensifies:

*“We have higher demands on **average length of stay** and such now, definitely. And there's nothing strange about it. You have to be able to deliver to your owners; there's nothing else to it. I mean, if I buy a shirt, I want it to hold together.”*

However, it is evident that despite being accountable for the financial performance of CareCompany, Managers have limited power to influence the budgetary targets received. One manager humorously describes the financial metrics as “*coming from god*,” indicating Managers perceived lack of control.

Besides the owner's expectations, CareCompay is continuously compelled by the Region and the patient admittance contracts to increase production without receiving additional compensation, which causes further financial stress:

“It is a great challenge to grow the organization in a healthy way when we do not receive any additional compensation, but instead need to negotiate with the Region and so on. As a private healthcare facility, it is not like we suddenly get a few extra millions. This is a big challenge.”

The accumulated financial pressure pushes Managers to focus on metrics such as average length of stay, occupancy rate, and average price per patient. In turn they exert pressure on the lower levels of the organization to conform. Resulting in internal discussions between the Employees and the Management, which is illustrated in the following quote:

“It is primarily the Employee's focus on patients that can make them lose the business mindset. Of course, one should focus on the patient, but within the compensation framework and business model that we are striving for. In this, there can definitely be differing opinions, where some do not want to look at the financials but rather focus on the patients only.”

Moreover, the implementation of the financial metrics are further complicated by the fact that CareCompany's incentive system is underdeveloped, and that the Employee team (led by the Senior Consultant), rather than the Managers, possess the ultimate medical responsibility for the patients. Thus, the power to realize the financial metrics is primarily at the employee level while the responsibility of overseeing them is at the management level. Hence, going against the controllability principle within accounting, creating power imbalance:

“It's not really me or the other Managers who can shorten the average patient stays, but rather those who work closest to the patients...there are not many incentive systems to use, it is more about communicating that the business aspect isn't meeting our needs. And also asking how we can be of assistance. How can we increase efficiency?”

Employees' resistance to the business perspective evidently creates obstacles for the management in achieving its financial targets. Furthermore, Managers point out several factors causing the resistance, such as, the inherent inertia within the healthcare system, the general difficulties of implementing change, and the specific cultural aspects of CareCompany:

“With the average patient stay, although it can be other situations as well, it is about changing a whole culture where Employees are used to working in a certain way for a long period of time. The situation involves people with a big heart for patients, and getting them to work more cost-efficiently and simultaneously making sure that their big heart prevails as well as the quality, is a big challenge.”

When asked *why* they think Employees might deprioritize financial metrics, Managers mention the emotional connection to patients together with a core ideology that may naturally

collide with business considerations, indirectly referring to the medical professionalism and the business logic:

“The disagreement could also be due to a fundamental ideology that one has. How one thinks about basic values and opinions. I don't think everyone understands that there actually is a wallet involved as well.”

Additionally, a manager states that Employees might not only resist due to patient considerations but also because the lack of personal fulfillment, which is linked to their professional identity:

*“Employees can stress that they do not want to let patients go, as **they** want to personally provide further care in order to fulfill **their** full capacity to the patient, although the patient might be better off at home or at the next healthcare institution”*

Furthermore, while some Employees are described as resistant to financial objectives there can also be a general sense of disinterest for goals and financial metrics, which according to Managers may be attributed to a lack of knowledge and communication:

“I believe that as long as Employees feel that they have a functional schedule and the basic conditions for their work is met, it doesn't matter too much whether we are HealthGroup, or municipally owned, or have another owner, as long as the daily operations work. For example if there is work clothes available every time they come to the locker, and ideally, the bus stops right outside. I find that people are more interested in having their daily routine work smoothly. They don't care much about where the salary comes from as long as they have a good work environment and workplace.”

In brief, Managers are tasked with balancing the financial demands from the owners with the Employees' concern for their profession and patients, as illustrated by a manager:

“I mean, one might say that I am in the crossfire between the businessmen/the business area manager, and my Unit Managers, who are themselves in the crossfire between me and their Employees on the floor, so we are all just in different crossfires.”

4.4.2 Employee Perspective

The financial metrics are enforced top-down and Employees have very limited ability to affect the chosen targets but are still required to follow up on them continuously. From their

perspective, the financial metrics are seen as an unavoidable compromise. However, there is still a common understanding and respect for the perspective of financial sustainability, but it is mostly viewed as a necessity to enable the operation:

“Of course, one understands that Managers and owners have to consider the financial aspects. But for those of us who are more involved and want to ensure the best for the patient, it's difficult when we see that the quality is somewhat declining.”

“One wants to have a sustainable economy, so I think that even if one is not an economist, everyone has their own personal finances that they manage. Everyone deals with finances, and then to be at work and only think about patients without knowing anything about the financial side doesn't feel right. It's appreciated to know that we are doing well financially.”

As Employees and Senior Consultants are directly responsible for patient outcomes, their collaboration is crucial for maintaining cost efficiency. The balancing act of adhering to the financial metrics, and still uphold the appropriate patient quality care is described by a Senior Consultant as:

“I feel a responsibility to represent the patients. If it has been decided that a patient will stay for a number of days due to its contract, and I say we have to extend it by two days, and I can motivate this then I am the one who decides when a patient should be discharged. I hold the medical responsibility. But then, I also need to be able to look my bosses in the eye, so obviously, it's a balancing act.”

Nevertheless, in certain situations, Employees worry that the emphasis on financial objectives compromise the patient quality care and undermine the purpose of the profession. They feel that their commitment to patients is being disfavoured by financial targets, which are seen as coercive instruments to increase compliance rather than enable their work (Jordan & Messner, 2012). For them, the goal is to address human needs, not to generate profit, and hence these metrics do not align with their motivation to work:

“Sometimes I feel like it becomes about: Now we have to think about money, money, money, and that the quality care is compromised because of it. And I understand that they need to consider the economy but it's disappointing when I perceive that the quality may be compromised.”

Moreover, when these tensions surface, Employees are emotionally triggered. A manager describes the emotional response when requesting the discharge of a patient:

“When I, as a manager and also consultant, asked to discharge a patient, an employee reacted very emotionally and said that they had further rehabilitation they wanted to pursue! But in my opinion both from a patient and business perspective it was time that the patient went home to their family and moved to the outpatient care.”

Another manager describes that:

“In these situations of debate, there is a sense of frustration among Employees. The bigger the patient-heart, the greater the frustration.”

As illustrated above, Employees argue in accordance with their medical professionalism as further emphasized by a manager:

“Employees mostly argue from the perspective that: No, this is too fast. We can't finish this quickly, the patient needs to stay longer. So it's mostly about the patient perspective... Some employees show greater understanding in the fact that we have to shorten the average duration of stay for patients, while others just want to give more and more.”

4.4.3 Spectrum of Perceived Compatibility Between Logics

It is evident that Employees in general perceive the financial metrics, backed by the business logic, as more conflicting than the Managers. From the debate, it becomes clear that individuals' inherent perceived compatibility between the two logics vary. The empirics show that the overall pattern of compatibility may be viewed as a *spectrum* where the more strictly a group or individual adheres to a single logic, the more likely they are to encounter conflicts towards the opposing one. Hence, in situations where financial metrics cause tensions, Managers are less inclined to scrutinize the business perspective than Employees, because of their more compatible perception. Managers employ arguments suggesting that financial metrics will benefit the company and, by extension, additional patients as well. Demonstrating a preference for harmonizing the relationship between the different logics:

*“An important metric we are currently working on is to shorten our average length of stay. This is in order to be able to **help more patients** and to make sure we have a **sound financial situation**.”*

Interestingly, a manager portrayed this perceived compatibility not as an inherent trait, but rather as an internal process that has unfolded over time:

“I have also made my journey, wondering about this private equity-owned situation, what happens now, and will there be tougher financial targets and so forth, but I also think that you definitely gain more strength in a larger organization with support functions and systems.”

The interviewee describes a shift from focusing primarily on the medical professionalism at the start of their career, to gradually embracing the business logic, and eventually achieving a higher perception of compatibility. This transition is partly attributed to Managers' close collaboration with HealthGroup and the significant institutional pressures they face. The analysis indicates that institutional pressure progressively compels individuals to reconcile logics:

“The more we collaborate and work together, the closer our values align.”

As a result, Managers, who are directly exposed to HealthGroup and CapitalPartners, view the business mindset as less conflicting. We thus recognize a generic pattern in which the individuals within the organization who work closer to the owners – where the financial metrics originate from – are more likely to support them. Therefore, Managers tend to react less emotionally to value-based conflicts as they do not work directly with patients, and do not perceive that their profession is being questioned. Given this rationale, as Employees are not directly in contact with CapitalPartners or HealthGroup, they do not prioritize financial performance to the same extent as Managers. Positioned at the other end of the organization, Employees are primarily engaged in clinical work and thus predominantly represent the needs of patients, who are their most direct stakeholder.

Furthermore, the power imbalance makes the conflict even more challenging to resolve. On one hand, CapitalPartners as the owners and financiers of the organization constitute a significant authority over its operations. On the other hand, Employees exert a more formal power over patient care and, consequently, profitability because of their expertise. The power imbalance positions Managers in the challenging role of mediating between these two essential groups. This relates to the broader spectrum where the owners favor the business logic, Managers find themselves in a balancing act, and Employees lean towards medical professionalism. The spectrum is evidently closely related to the organizational hierarchy, which relates to the perception of various stakeholders and their power to influence the PMS.

4.4.4 Organizational Reactions to the Conflict

From the Employees' perspective, the perceived coerciveness of the metrics has increased and the financial focus has intensified, due to pressure from HealthGroup and CapitalPartners. This transparency and visibility of power in implementation, seems to impact the Employees' identification with HealthGroup and CapitalPartners, as both Managers and Employees note that some have started to distance themselves from private healthcare:

“Until we were bought by HealthGroup, which is owned by CapitalPartners, there was not much internal discussions, everyone has always been conscious that we are privately owned. However, discussions have begun to surface among some of the Employees. They view the owners as venture capitalists who will eventually sell us, extracting as much resources as possible in the process. Not everyone shares this view; some appreciate HealthGroup or are more neutral, but there are still those who express concerns.”

“I do not think privately owned healthcare is that good. There is too much focus on profitability which may affect the quality negatively. I think that is my fear with too much focus on profitability.”

Adding to this, some also react by making a clear distinction between CareCompany and HealthGroup, in order to avoid associating their professional situation with the parent companies:

“I definitely identify very strongly with CareCompany. HealthGroup is a bit more unclear. I know they own us, they are the ones who make the decisions. But it's the CareCompany spirit and those of us who work here that I identify with. Much more than HealthGroup. That's how it is.”

This has confused managers, who do not share Employees' view, and point out that CareCompany has always been privately owned. They find it strange that it is now becoming an issue:

“Some think that this is CareCompany not HealthGroup, which is something else. This is strange since we have always been privately financed and it is not like a venture capitalists goal is to demolish the organizations, rather the opposite, they want it to grow”

It appears that when financial metrics impact employee autonomy and values, it can provoke resistance and emotional reactions. As a result, Employees may gain a negative perception of the underlying stakeholder, causing them to decouple CareCompany from HealthGroup and CapitalPartners. Managers, in contrast, perceive the logics as more compatible as they are directly exposed to HealthGroup and do not share the Employees' view.

This shift underscores the tensions that arise when organizational and professional values diverge. In short, the situation highlights the complexity of enforcing metrics of profitability throughout CareCompany and balancing it with Employees' perception of “good enough” quality from their professional standpoint.

4.5 Analysis and Summary of Key Findings

To summarize, our research results in three key findings that contribute to the existing body of literature. Firstly, we find that top-down enforced and coercively perceived metrics, embodying values conflicting with individuals' logic, can create a negative perception of the underlying stakeholder. As a result, Employees react by socially decoupling from the stakeholder whose logic contradicts their own. High transparency and visibility of power within CareCompany act as a negative catalyst to this, as Employees' perceive that the financial metrics and increased financial focus originate from HealthGroup and CapitalPartners, rather than from the Managers. This reaction is driven by the emotional distress experienced when the enforced metrics do not coincide with Employees' view of their profession and organizational purpose.

Secondly, our findings reveal that metrics heavily influenced by one major logic and backed by one stakeholder are more prone to intra-organizational conflict. No other category of metrics, except the financial, were mentioned to cause recurring discussions at the operational level of CareCompany.

Thirdly, alluding to our second contribution, the level of perceived compatibility between logics, at the individual/group level, can be visualized as a spectrum. The more rigidly a group or individual adheres to a single logic, the greater the likelihood of being emotionally triggered when experiencing internal conflicts with opposing logics, thus resisting the PMS. Although everyone at CareCompany adheres to both the medical professionalism and the business logic to some extent, Managers tend to perceive the logics as more compatible than the Employees who work closer to the patients. This is attributed to the institutional pressure

that Managers face in their direct exposure to HealthGroup. Resulting in that the spectrum closely correlates with the hierarchical structure of the organization. Consequently, when the ambiguous situation between patient quality care and profitability arises, Managers argue from a harmonical standpoint, while Employees take a defensive and emotional position, arguing based on medical professionalism. Furthermore, the stronger emotional connection individuals have towards their dominant logic, and the further away coalitions within an organization are from each other on the spectrum, the more frequent and intense conflicts concerning the PMS, directly impacting the effectiveness of the system. The finding is particularly relevant under circumstances of power imbalance, where the employees have the operational power due to their profession and the owners have the ultimate financial power. This significant practical value as a group's or individual's position on the spectrum may be used to predict potential resistance when implementing PMS in organizations more generally.

In brief, our findings mutually reinforce each other. Essentially, when metrics are implemented by a single stakeholder, embodying a strong and distinct logic, they are more prone to cause conflict. The more employees perceive the underlying logic as incompatible with their own, the stronger their emotional reaction when provoked, and the more likely they are to reject the metrics imposed upon them, and as a consequence decouple from the associated stakeholder.

5 Discussion

The existing literature on PMS in institutional complex settings, predominantly centers on three main areas: the design process (Chenhall et al., 2013; Chenhall et al., 2017; Sundin et al., 2010), the implementation strategies (Pache & Santos, 2013; Kurunmäki, 2004; Dent, 1991), and the usage of these systems (Carlsson-Wall, Kraus, & Messner, 2016; Morinière & Georgescu, 2022). Within the domain, the primary focus has been either on field and management-level dynamics or on interactions between external stakeholders and the different power struggles therein. Previous research show that stakeholders and institutional logics significantly influence PMS in all the three areas, consequently embedding PMS with underlying values. This embedding causes the metrics to perform a more expressive rather than a neutral function and, as a result, PMS serve as a platform for various institutional logics to interact (Brignall & Modell, 2000; Chenhall et al., 2013). In this interaction, groups with different values may emerge (Pache & Santos, 2010; Greenwood et al., 2011).

Our research concurs with the existing literature but further elaborates by examining the impact on individuals and their reactions. While the literature acknowledges that these tensions may naturally create obstacles that can lead to the formation of coalitions, the specific manifestations of these tensions at the operational level and the individuals' reactions – especially when metrics are coercive – remain underexplored. By taking stakeholder influence and the underlying logics of PMS as a given, we bridge this gap and enhance the existing body of literature by addressing the following research question:

How and why do tensions regarding performance measurement systems arise in complex institutional settings, and how do individuals within these organizations react to them?

Addressing this gap is crucial for several reasons. To begin with, the operational level is where the PMS is implemented. It is at this level – not in management or through interactions with external stakeholders – that the success of PMS can truly be assessed. Therefore, understanding why and how resistance or conflict arise and, in turn, affect the individuals at the operational level is essential, as it directly impacts the effectiveness of the system. Additionally, investigating how these dynamics create reactions within an organization will help to explore the potential consequences of conflicting institutional logics on PMS. In addition, this offers practical implications for resolving and proactively mitigating potential conflicts.

Our case-organization provides an ideal setting as the healthcare sector is known for its duality of logics, and medical professionals are renowned for their strong intrinsic motivation and deep emotional commitment to their work. At CareCompany, these characteristics are put in plain contrast to the profitability objectives of the owners, CapitalPartners. Although there is previous research concerning the healthcare sector (Brignall & Modell, 2000; Reay & Hinings, 2009; Kurunmäki, 2004; Morinière & Georgescu, 2022), it is primarily in the context of New Public Management, and without specifically analyzing the settings of private equity ownership, making our empirics unique.

5.1 Contributions

Our research offers novel insights and enhances the understanding of the emergence of conflicts regarding PMS. The contribution is threefold as we add to the domain of institutional logics, performance measurement systems in institutional complexity, and performance measurement systems.

Our first contribution is within the existing literature of institutional logics and institutional complexity (e.g. Reay & Hinings, 2009; Greenwood et al., 2011; Thornton & Ocasio, 2008; Thornton et al., 2012; Pache & Santos, 2013). While prior studies focus on the variation of compatibility between logics across fields and organizations (Greenwood et al., 2011), and depending on the situation (Carlsson-Wall, Kraus, & Messner, 2016), our research further broadens the perspective by illustrating that compatibility also varies between *individuals* within organizations. Supported by our empirical findings, individuals' perceived compatibility can be likened to a spectrum. The spectrum correlates with the hierarchical structure of an organization as direct exposure to a stakeholders representing an opposing logic may gradually compel individuals to adjust their perception of compatibility over time. This contributes to deepening the understanding of the coexistence of multiple logics, as the spectrum suggests an endless possibility of variation in perceived compatibility within an organization. The findings also indicate that adopting a flatter organizational structure could potentially increase harmony between logics within an organization.

Our second contribution is to the domain of performance measurement systems within institutional complexity. Building on the foundation of existing research, we presume that conflicting logics influence PMS and that tensions may occur as a consequence of the values embedded in the metrics (e.g. Chenhall et al., 2013; Carlsson-Wall, Kraus, & Messner, 2016; Brignall & Modell, 2000; Morinière & Georgescu, 2022; Bedford et al., 2019; Chenhall et al., 2017; Pache & Santos, 2010; Kurunmäki 2004; Sundin et al. 2010; Pache & Santos, 2013). To advance the conversation, we demonstrate that the stronger emotional connection individuals have to their dominant logic, and the greater the distance between groups on the spectrum, the higher the probability of emotional reactions leading to conflict and resistance regarding metrics backed by an opposing logic. The contribution highlights the importance of anticipating what logics are present not only at the external and management level but also at the operational level, as it may greatly impact the effectiveness of PMS. Consequently, we enhance the comprehension of how and why conflicts in PMS arise by offering insights into individuals' reactions to value-based conflicts.

The last contribution is within the domain of performance measurement systems. We build upon the literature regarding the impact of PMS as coercive or enabling (Jordan S. & Messner, 2012; Wouters & Wilderom, 2008; Adler & Borys, 1996; Ahrens & Chapman, 2004) and, additionally, explore the expressive role of PMS in facilitating or hindering

productive debate (Chenhall et al., 2013; Chenhall et al., 2017). At CareCompany, the formalization of control systems – marked by increased evaluation pressure and decreased flexibility – has intensified the perception of PMS as coercive at the operational level, aligning with the findings of Jordan, S., & Messner (2012). Its top-down enforcement and absence of value incorporation from the employee's in the development process, stifles productive debate due to lack of 'give and take', which leads to resistance of the metrics (Wouters & Wilderom, 2008; Chenhall et al., 2013; Chenhall et al., 2017). Furthermore, our contribution to the PMS literature is twofold but interrelated. First, we underscore the potential negative effects of coercive formalization in the absence of co-creation, which results in employees distancing themselves not only from the metrics, as previously suggested, but also from the underlying stakeholders representing those metrics. Second, we observe that transparency and visibility of power regarding the origins of the values in the PMS can act as a negative catalyst for this. Our findings highlight the potential risk of coercive systems in conjunction with strong values underlying metrics and organizations.

5.2 Limitations and Future Research

Due to time constraints and the scope of research, our data collection was limited and we acknowledge that a more extensive dataset may have further enriched our findings. Future research could benefit from increasing the number of interviewees, in order to refine the identified patterns and represent even more diverse individual perspectives. This expansion would not only broaden the understanding of the domain but could also reveal additional reactions and perspectives related to the tensions observed.

Another aspect of consideration is the industry-specific context of our study. The healthcare sector is characterized by organizational members having strong values and beliefs and intense institutional complexity, which was deemed ideal for our research. However, subtler findings may emerge within industries with lower complexity. This opens up for future research to explore the applicability of our findings across different sectors and examine individual's reactions to PMS when organizational members are not as strongly committed to various values and beliefs.

Finally, we strongly encourage future research to conduct longitude studies in order to explore the long-term implications of our findings. The empirical evidence presented in this study opens up for investigating the evolving nature of conflicts and individual's perceived

compatibility across the spectrum over time. This research could shed light on how the dynamics impact the effectiveness and success of PMS in aligning objectives and, consequently, impact organizational members in the long run.

Appendix

Appendix 1: Interview details

Date	Position	Setting	Recording	Length
19-02-2024	Senior Manager 1	In person	Yes	1:19:54
22-02-2024	Employee	In person	Yes	36:36
23-02-2024	Business Controller	Online (Microsoft Teams)	Yes	32:22
01-03-2024	Senior Manager 2	Online (Microsoft Teams)	Yes	44:55
25-03-2024	Senior Manager 3	Online (Microsoft Teams)	Yes	57:56
28-03-2024	Unit Manager 1	Online (Microsoft Teams)	Yes	53:12
10-04-2024	Employee	Online (Microsoft Teams)	Yes	49:58
10-04-2024	Employee	Online (Microsoft Teams)	Yes	52:51
				$\mu = 50:58$

Appendix 2: Interview Guide Extract

The following guide was altered for each interview to suit the specific conditions and role of the interviewee. Mostly, questions were not posted as directly as below but rather reformulated and softened for the interviewees to provide a more flexible and less biased answer. The order of the questions was also changed depending on the approach aimed for. Some interviews started on the theme of institutional logics rather than PMS to investigate if this approach would provide different answers.

Formalities:

- Introducing ourselves and the aim of the study. Informing about the anonymity and clarifying the concept of Performance Measurement Systems.

Introduction:

- Can you introduce yourself and describe your role at CareCompany?
- Tell us about your previous roles and working history, both within and outside of CareCompany.
- What motivated you to pursue this career and what drives you today in your work?

Organizational Structure and Roles:

- Who do you work with most closely on a daily basis (individuals/groups)?
- To whom do you report, and who reports to you?
- What are your main responsibilities at CareCompany?

Performance Measurement System (PMS) Design:

- What are the key performance indicators (KPIs) and goals that influence your work?
- How are these goals set and who is involved in the process? (Describe the hierarchy and power dynamics involved)
- How are general and individual goals communicated to you, and can you influence these goals?

PMS in Operation:

- Which goals do you find most critical, and why?
- Do you perceive a consensus within HealthGroup on how priority areas should be managed, or are there significant differences of opinion between groups or individuals?
- Are there recurring situations that always create more discussion on how to prioritize or manage operations, particularly between financial and ethical considerations?

Institutional Logics and Complexity:

- How do you balance different institutional logics in your daily work, such as patient care versus business objectives?
- In which situations do these logics conflict, and how are such conflicts navigated within the organization?

Power Dynamics:

- How is the official hierarchy observed in day-to-day operations?
- Do official goals permeate daily work effectively, or do employees selectively prioritize goals based on personal preference?
- Who typically “wins” in discussions or conflicts, and why?

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