



LUND UNIVERSITY
School of Economics and Management

Performance measurement for better or for worse?

A study in Swedish primary care

by

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May 2017

Master's Programme in Accounting and Finance

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Abstract

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| Title | Performance measurement for better or for worse? A study in Swedish primary care |
| Seminar date | 31 May 2017 |
| Course | BUSN79 Business Administration Degree Project in Accounting and Finance, 15 credits |
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| Keywords | Privatization, public sector, primary care, management control, performance measurement |
| Purpose | The purpose of this thesis is to generate an understanding of the management control used in Swedish primary care, by analysing the similarities and differences between publicly and privately owned primary care providers. |
| Theoretical framework | The main theories that the theoretical framework used in this thesis is based on are theory regarding management control, and performance management and measurement |
| Methodology | The method used in this explanatory multiple case study of Swedish primary care providers, is an inductive approach with a qualitative strategy. Documents from two private organizations and one public organization have been reviewed, as well as semi-structured interviews conducted with two employees in each organization. |
| Empirical foundation | The empirical data for this study was gathered from three case organisations within Swedish primary care, whereof 2 private companies and 1 public organisation. |
| Conclusions | The findings of this paper suggest that management control in Swedish primary care is highly dependent upon the context. Similarities and differences between private and public providers originates from the characteristics of the organisation and how they choose to adapt to the context. |

Acknowledgements

We would like to take the opportunity to express our genuine gratitude to our supervisor Anna Glenngård for her much appreciated encouragement, feedback and guidance throughout the process of writing this master thesis, and for her valuable insights in the public sector and primary care.

Additionally, we would like to show our appreciation to the interview respondents who volunteered to participate in our case study, for their time, commitment and valuable information that made this thesis possible.

Lund, May 23, 2017

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Table of Contents

| | |
|--|-----------|
| 1 INTRODUCTION | 6 |
| 1.1 BACKGROUND | 6 |
| 1.2 PROBLEMATIZATION | 7 |
| 1.3 RESEARCH PURPOSE | 8 |
| 1.4 OUTLINE OF THE THESIS..... | 9 |
| 2 THEORETICAL REVIEW | 10 |
| 2.1 MANAGEMENT CONTROL | 10 |
| 2.1.1 <i>Strategy and management control</i> | 10 |
| 2.1.2 <i>Management control systems</i> | 11 |
| 2.2 MANAGING PERFORMANCE | 12 |
| 2.2.1 <i>Performance management</i> | 12 |
| 2.2.2 <i>Performance measurement</i> | 13 |
| 2.2.3 <i>Performance measures</i> | 13 |
| 2.2.4 <i>Performance measurement system</i> | 14 |
| 2.3 THEORETICAL FRAMEWORK FOR ANALYSIS | 15 |
| 2.3.1 <i>Strategy and planning</i> | 16 |
| 2.3.2 <i>Measurement</i> | 16 |
| 2.3.3 <i>Setting targets</i> | 17 |
| 2.3.4 <i>Evaluation of performance</i> | 18 |
| 2.4 ANALYSIS MODEL | 19 |
| 3 METHODOLOGY..... | 20 |
| 3.1 RESEARCH APPROACH | 20 |
| 3.2 RESEARCH DESIGN..... | 21 |
| 3.2.1 <i>Case study</i> | 21 |
| 3.2.2 <i>Selection of cases</i> | 21 |
| 3.2.3 <i>Company description</i> | 22 |
| 3.3 DATA COLLECTION METHOD | 23 |
| 3.3.1 <i>Primary data</i> | 23 |
| 3.3.2 <i>Secondary data</i> | 25 |
| 3.3.3 <i>Literature review</i> | 25 |
| 3.4 DATA ANALYSIS..... | 26 |
| 3.5 RESEARCH CRITERIA..... | 26 |
| 3.5.1 <i>Validity</i> | 26 |
| 3.5.2 <i>Reliability</i> | 27 |
| 3.5.3 <i>Replicability</i> | 27 |
| 4 EMPIRICAL FINDINGS..... | 29 |
| 4.1 COMPANY A..... | 29 |
| 4.1.1 <i>Strategy and planning</i> | 29 |
| 4.1.2 <i>Measurements</i> | 31 |

| | |
|--|-----------|
| 4.1.3 Setting targets..... | 32 |
| 4.1.4 Evaluation of performance..... | 33 |
| 4.1.5 Summary | 34 |
| 4.2 COMPANY B..... | 35 |
| 4.2.1 Strategy and planning | 35 |
| 4.2.2 Measurements..... | 36 |
| 4.2.3 Setting targets..... | 37 |
| 4.2.4 Evaluation of performance..... | 38 |
| 4.2.5 Summary | 40 |
| 4.3 REGION SKÅNE | 40 |
| 4.3.1 Strategy and planning | 40 |
| 4.3.2 Measurements..... | 42 |
| 4.3.3 Setting targets..... | 44 |
| 4.3.4 Evaluation of performance..... | 44 |
| 4.3.5 Summary | 46 |
| 5 ANALYSIS AND DISCUSSION | 47 |
| 5.1 ANALYSIS OF EMPIRICAL RESULTS | 47 |
| 5.1.1 Strategy and planning | 47 |
| 5.1.2 Measurements..... | 48 |
| 5.1.3 Setting targets..... | 48 |
| 5.1.4 Evaluation of performance..... | 50 |
| 5.2 FINDINGS IN RELATION TO THEORY | 52 |
| 5.2.1 Strategy and planning | 52 |
| 5.2.2 Measurements..... | 53 |
| 5.2.3 Setting targets..... | 54 |
| 5.2.4 Evaluation of performance..... | 55 |
| 5.3 DISCUSSION OF RESULTS..... | 56 |
| 6 CONCLUSION | 58 |
| 6.1 FINDINGS..... | 58 |
| 6.2 CONTRIBUTIONS AND LIMITATIONS..... | 59 |
| 6.3 FUTURE RESEARCH | 59 |
| REFERENCES | 61 |
| APPENDIX..... | 64 |

1 Introduction

This chapter will introduce the thesis by broadly describing the debate and the split between public and private production of public services. Thereafter, the primary care in Sweden will be explained, together with a discussion regarding how to manage and control organisations in this context, which will lead to the purpose of the thesis. The chapter will lastly end with an outline of the rest of the thesis.

1.1 Background

Recently this spring, several doctors warned about a hard-hit primary care in Skåne. At many primary care clinics, the working environment is very strained and strenuous. Who is going to treat patients when the doctors are sick and cannot cope anymore? Sickness absence among employees has led to risks of threatening the patient safety, several doctors mean in an open letter to regional politicians (Sydsvenskan, 2017).

Questions about resource allocation in the public sector like this, regarding healthcare, education and social care concern all citizens, and often lead to heated debates (Adenfelt, Bergström, Krohwinkel & Winberg, 2015). Since public sector questions are important and concerns everyone in the society, the management in the sector currently tends to mostly focus on performance demands and measurement of results. Performance measurement seems to work better in theory than in reality, which has both ethical and professional consequences, since independence and individual judgment are set aside. When measurable results are the most interesting measures, the management of the public sector has come quite far from the basic ideas and values, and instead turned into an audit society (Zaremba, 2013). Another popular and broad debate within the public sector is the one about the split between private and public production. The welfare debate has been characterized by a focus on companies' profits and profitmaking in the public sector, and even though this topic has been highly debated for several years, no consensus regarding whether to allow private providers or not, has been reached. In the 1970s and 1980s, privately owned companies in the public sector was a quite marginal phenomenon in Sweden. Since the early 1990s it has however changed, mostly because of changes in attitudes in some of the municipalities and county councils. Sweden has moved from a huge publicly owned and managed welfare sector, to being a pioneer for market reforms and an extensive privatization (Adenfelt et al. 2015).

According to the Health and Medical Care Act it is, since January 1, 2010, mandatory to provide a healthcare system which is based on a free choice for the users of primary care. (Hälso- och Sjukvårdslagen § 5, 2017) This law requires that all county councils provide their residents opportunities to choose providers of primary care without restrictions to a specific geographic area within the region, and the payment to the providers follow the choice of the individuals. The free choice of primary care is supposed to allow competition on equal terms for all providers, since the same rules apply for all, and individuals can choose a different primary care centre if you are not satisfied with the one where you are enrolled (Glenngård & Anell, 2012). The respective county council decides by themselves how the conditions of

choice should be designed, which has led to assignments, provider payment systems, and cost responsibility being designed in different ways (Anell, Nylander & Glenngård, 2012). Furthermore, the choice reform has led to the amount of privately owned primary care centres have increased significantly to represent more than 40 percent of the providers of the service (Angelis, Glenngård & Jordahl, 2016). Additionally, in 2013, 43 percent of all the visits within primary care were made at other providers than the publicly owned county councils (Adenfelt et al. 2015).

The primary care is the first instance in the Swedish healthcare system and its purpose is to fulfil the general need for healthcare which does not require the specialist knowledge, equipment, and competences of a hospital. The primary care consists of approximately 1200 primary care centres located in 21 county councils. It is the county councils who decides the conditions for approving providers of primary care, and what specific healthcare services that needs to be provided by the primary care centres vary between county councils. For providers to be approved they must comply with the financial, organisational and quality requirements for accreditation as specified by the county council. The contract with conditions for accreditation is signed between the county council and the managing director at each primary care clinic (Angelis, Glenngård & Jordahl, 2016).

Each centre for primary care have one clinical director and one managing director. The clinical director is always a doctor who has the overall medical responsibility, while the managing director usually not is a doctor but still has a background within healthcare. The managing director is responsible for the quality of the service and the safety of the patients. The design of the previously mentioned conditions for accreditation, and the provider payment systems has consequences for how the managing directors can run their primary care clinics. Differences in these conditions for accreditation and the monitoring of provider activities can result in better or worse conditions for the managers to design their operations, and they hence need to control and manage accordingly (Angelis, Glenngård & Jordahl, 2016).

1.2 Problematization

Private and public production of primary care is still today in the spotlight of the political debate, and highlights other major challenges such as how the public sector should be controlled and managed (Adenfelt et al. 2015). Actually, the interest in primary care has increased, together with many questions about how to best organize and manage the operations (Anell, 2015).

Finding an appropriate type of management and control in the public sector seems to be a rather complicated task, since privately owned and publicly owned organisations tends to be quite different in a several areas. For instance, Boyne (2002) made a summarization of previous research in public and private organisations where the research was categorised into four different areas: environmental differences, goal differences, structural differences and

differences in managerial values. The main findings of the study were that public organisations often are more bureaucratic, have a higher focus on regulation and are more risk averse. Additionally, managers in the public organisations proved to be intrinsically motivated and focus more on welfare than on profitability, with a lower level of job involvement. The private sector organisations, however, have in comparison a greater task and goal clarity, and the managers are rather extrinsically motivated while focusing highly on payment and profitability (Boyne, 2002).

The previous research about management control in primary care generally have a quantitative approach and a broader view is taken. Yet, the evidence regarding differences in performance attributable to ownership in Swedish primary care, are mixed. Several researchers find differences in private and public providers' performance, and basically just as many do not (Glenngård & Anell, 2012; Anell, Nylinder & Glenngård, 2012; Glenngård, 2013). However, there is a lack of studies in how they are managed.

Delfgaauw, Dur, Propper and Smith (2011) made a comparison in management practises in the social care sector, and suggest potential differences between private and public organisations. In fact, managers in public organisations seemed to have a lower managerial quality, but higher altruism. Similar results were found in the only Swedish study, where Angelis, Glenngård and Jordahl (2016) examined management in Swedish primary care based on a grading of best practice. The results of the study showed a high level of management score, where the privately owned organisations showed a bit higher in general. However, the differences in management was higher within the two different types of organizations (private organizations had both the highest and lowest score), than between the two types.

As above shown, there is currently a lack of knowledge regarding management control within Swedish primary care. The previous publications have a quantitative approach with an overall/comprehensive perspective, and is most often based on secondary data. Accordingly, there is proved to be some differences in management control between private and public organisations, but it is difficult to get an understanding of the differences. Few attempts have been made to get an in-depth perspective of how and why the management control in primary care differs. Hence, to get a thorough understanding, a deeper analysis in a qualitative study is required.

1.3 Research purpose

The purpose of this thesis is to generate an understanding of the management control used in Swedish primary care, by analysing the similarities and differences between publicly and privately owned primary care providers.

1.4 Outline of the thesis

The remaining part of this thesis is divided into the following sections:

Chapter 2 consists of a theory section that describes which theories that are chosen as the framework for the thesis. The theory includes information from scientific articles and relevant literature, and ends with presenting our theoretical framework for analysis.

Chapter 3 describes the research approach and design used. The chosen method is described and justified. Some limitations are pointed out and the efforts taken to avoid them.

Chapter 4 makes up the responses and the results of the examination of the three case organisations, consisting of both secondary data in form of examined documents, as well as primary data from interviews and email contact.

Chapter 5 analyses the collected data in relation to each other and to the theoretical framework for analysis, and thereafter discusses the results.

Chapter 6 consists of the conclusions of the thesis. The purpose is answered by presenting the main findings. The last part of this chapter also present limitations of this thesis, and provides instructions for future research.

2 Theoretical review

This chapter contains a thorough description of management control, starting with presenting a discussion regarding strategy and management control systems, and further describes the concept of performance management systems. Lastly, emerging from the theory described, our theoretical framework for analysis is presented, containing four components; strategy and planning, measurement, setting targets, and evaluation of performance.

2.1 Management control

2.1.1 Strategy and management control

The meaning of strategy originates from the military and was defined as “a plan which leads to the destruction of one’s enemies through the deployment and use of one’s resources” (Worrall, Collinge & Bill, 1998, p.474). In business, the word could have a similar meaning. The strategy concept in business was defined by Porter (1996, p.68) as “the creation of a unique valuable position, involving a different set of activities”. Where the strategy would allow the organisation to create a competitive advantage by choosing activities that are different from the rivals’, and in that sense, defeat its competition. Thus, the purpose of having a business strategy is to position the firm so it has a competitive advantage (Hopper, Northcott & Scapens, 2007). Yet, another definition describes strategy as the plan for reaching the company’s goal by satisfying their customers more efficiently and effective than their competitors (Neely, Gregory & Platts, 1995; 2005).

To implement a strategy and align the actions of the individuals with the overall organisational strategy of the organisation, Simons (1994) argue that managers uses different formal control tools. Furthermore, Bedford, Malmi & Sandelin (2016) mean that the chosen business strategy and the different strategic contexts an organization can operate in will affect the effectiveness of any management controls used. Additionally, interdependencies between the different management controls and how these vary depends on the strategic context of the firm. Thus, it is contextual factors that determine the effectiveness of any management controls, and the controls depends on both the firm's strategy and how well the controls fit with each other (Bedford, Malmi & Sandelin, 2016).

Simons (1994, p.170) defines management controls as "the formal information-based routines and procedures used by managers to maintain or alter patterns in organizational activities". Similarly, Malmi and Brown (2008) describes management controls as all devices and systems which managers use to ensure that the behaviours and decisions of their employees are consistent with the organisations objectives and strategies. Furthermore, Simons (1994; 1995) mentions four different areas of systems that managers use which each includes these different control tools (see figure 1 below). The first area is the *belief systems*, which is used to guide opportunity seeking behaviour and the core values of the organisation. This system contains several management control tools, such as the vision and mission statements and credos. The next systems are the *boundary systems*, which purpose is to set the frames or the limits of freedom of creativity within the organisation and the risks to be avoided. This is

done by using control tools such as rules, laws and codes of business conduct. The third systems are used to ensure that the strategic goals of the organisation will be achieved, and is named the *diagnostic control systems*. The system consists of different feedback-systems and management control tools to overview the performance of the organisation for example different sorts of budgets and goal and monitoring systems. The last systems are the *interactive control systems*, which mean that the managers personally involve themselves in the daily operations by having a dialogue with the employees, but also to bring attention to strategic uncertainties and create a sense of emergence towards the fulfilment of strategy. The management can make any of the previous mentioned control systems to interactive control systems by involvement (Simons, 1994).

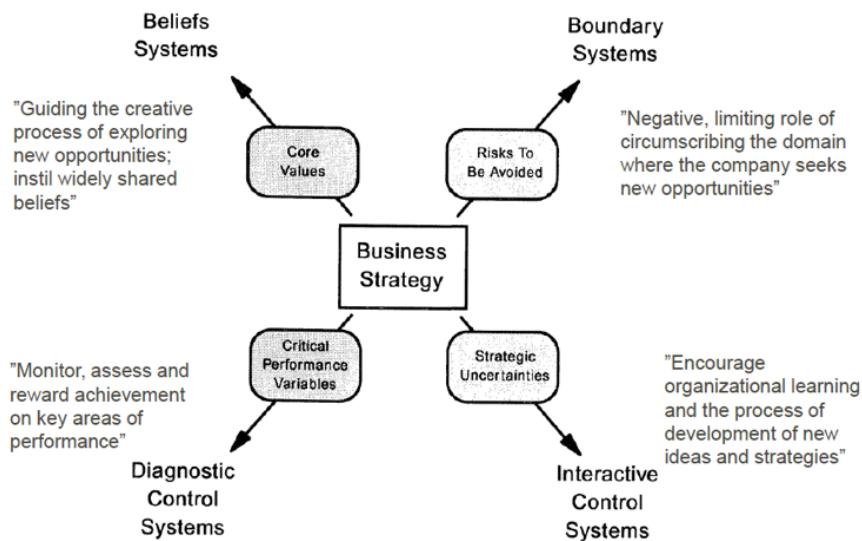


Figure 1. Controlling business strategy: Framework for analysis

Source: Revised from Simons (1994, p.173)

2.1.2 Management control systems

Malmi and Brown (2008) discuss the fact that the different controls tools work together as a package and should support each other, hence the control tools make up the *management control system* of an organisation. A management control system contains both formal controls, such as performance evaluations and budgeting, and informal controls such as shared values, culture, norms, and self-control (Hopper, Northcott & Scapens, 2007). Simons (1995) views a management control system as the means used by senior managers to successfully implement their intended strategies.

According to Malmi and Brown (2008) the efficiency of the management control system depends on the ability of the individual management controls to support and strengthen each other. Furthermore, the management control system consists of five main elements (see figure 2 below). The first element is the *cultural controls*, which include values, beliefs and norms that affect the employee behaviour. *Planning* is the second element and discuss the how the operations is supposed to fulfil the firm's vision by setting different goals and targets, and

how they can reach them and what commitment and behaviour that is required from the people within the organisation. The third element is called *cybernetic controls*, which includes factors such as measurements, standardization of performance and feedback. The next element is called *reward and compensation*, and its purpose is to motivate and increase performance and to control the direction of effort. The last element, *administrative controls*, have more of a governance approach which ensures accountability for the employees' behaviour and how tasks should be performed (Malmi & Brown, 2008).

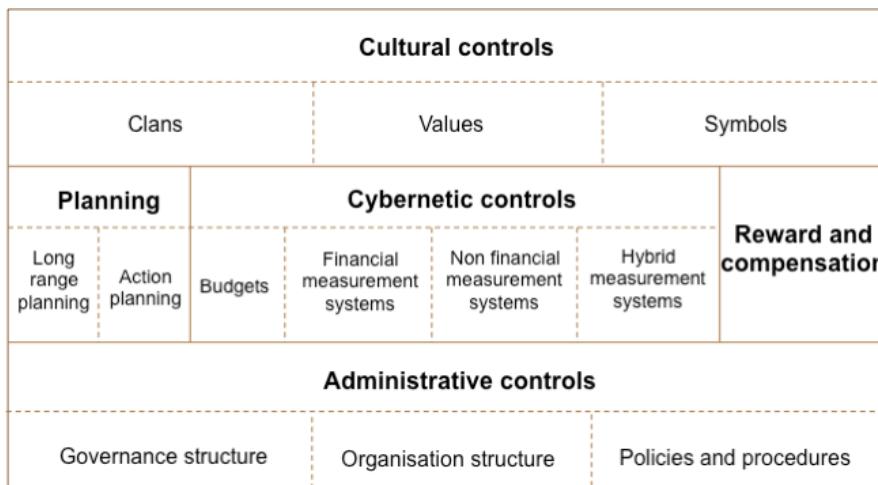


Figure 2. Management control systems package

Source: Malmi and Brown (2008, p.291)

In addition to this, Ahrens and Chapman (2004) discuss two different types of management controls which they name *enabling* and *coercive* control. Simplistically put, coercive control is more related to traditional organisation structures which are top down managed, and to mechanistic management control systems. The concept of formal coercive controls aims to create a fool proof system with strict rules, repetition and formal control, and relies heavily on cybernetic controls mentioned above. Enabling controls, however, is more common in organic organisations, where the formal control system instead focuses on supporting the employees and helping them to solve contingencies. Furthermore, these firms have a more decentralised structure, more variety of tasks and a higher knowledge requirement in the different tasks, and their success factors consists of flexibility and communications. However, important to notice is that no organisation use only coercive or enabling controls, but rather use a mix of both in their management control systems (Ahrens & Chapman, 2004).

2.2 Managing performance

2.2.1 Performance management

The concept of management control systems is usually intertwined with *performance management*, and questions in both these areas are typically complex and linked together (Ferreira & Otley, 2009). Performance management plays a critical role in finding out how

well the organisation is doing, which is a central question for management to handle with their best ability (Hopper, Northcott & Scapens, 2007). Performance management begins with purposes and objectives (Ferreira & Otley, 2009). Therefore, managing performance can contribute to revealing how well the firm achieve their corporate objectives by evaluation and continuous follow-up, and thereby identify required improvements to be made (Hopper, Northcott & Scapens, 2007).

Neely, Gregory & Platts (2005) states that the level of performance a business achieves is a function of the efficiency and effectiveness of the actions it undertakes. Furthermore, they mean that organizations perform and achieve their goals, by satisfying their customers with greater efficiency and effectiveness than their competitors. Richard, Devinney, Yip and Johnson (2009) also states that performance is one type of effectiveness indicator, and hence organisational effectiveness captures organizational performance. Furthermore, they highlight the fact that small and large firms are likely to perform in different manners, which indicates that performance can either be driven by the industry in which they operate, or be specific to the firm (Richard et al. 2009).

2.2.2 Performance measurement

Performance measurement can be defined as the process of quantifying the efficiency and effectiveness of action (Neely, Gregory & Platts, 2005). Performance measurement can contribute to a better understanding of how the business works, are often well-integrated with the planning and control system of the organization, and facilitates implementation of change (Arwidi & Jönsson, 2010). Furthermore, performance measurement is a management control tool that can help managers to make sure that different levels and departments in the organization strive for the same goals as the whole organization (Franco-Santos, Lucianetti & Bourne, 2012).

On the other hand, the measurement process in a business can be easy to manipulate and result in overflow of information, and be overly focused on financial performance and the short run (Arwidi & Jönsson, 2010). Power (2004) identified a trend of measurement being a very frequently used process, and questioned whether it really is necessary to measure in order to manage. Furthermore, he argues that it has become socially accepted to trust numbers, and performance measurement are used as common language for making better judgments in organisations. However, it has been proven that measurement-managed companies seem to outperform non-measurement-managed companies (Hopper, Northcott & Scapens, 2007).

2.2.3 Performance measures

A *performance measure* can be defined as a metric used to quantify the efficiency and/or effectiveness of an action (Neely, Gregory & Platts, 2005). Measurement of organisational performance is central, and to achieve coherence within the organisation, it is of high importance that the measures are grounded in the business strategy (Hopper, Northcott & Scapens, 2007). An optimal measure should match the business strategy, and be consistent

with the organization's culture (Neely, Gregory & Platts, 2005). For an individual employee, performance measures create a link between their own behaviour and the organization's goals (Ittner & Larcker, 1998). Performance measures can range from financial to non-financial, and be implicitly or explicitly linked to strategy. The measures can be used to inform decision making and evaluate both organizational and managerial performance, including having influence on financial and nonfinancial rewards (Franco-Santos, Lucianetti & Bourne, 2012).

Thus, Franco-Santos, Lucianetti and Bourne (2012) mean that performance measures often are used to operationalize strategic objectives, and they can have consequences on different fields in an organization. Additionally, performance measures can be used for decision support at management level and on operational level, to provide a better picture of customer and product profitability, and to provide information for external reporting (Arwidi & Jönsson, 2010).

A common saying is "what gets measured gets done" (Anthony, Govindarajan, Hartmann, Kraus & Nilsson, 2014), and we probably measure more things in more detail than is functionally necessary, and we often do so for reasons that are cultural and social, rather than for technical use (Power, 2004). Arwidi and Jönsson (2010) studied Swedish management control practices with focus on performance measurement and budgeting, and found a gradual shift in performance measures. From focusing on financial measures alone, to also focus on measures concerning the market, customers, quality and production. However, the measures used, are unlikely to capture the full complexity of the whole organisation (Hopper, Northcott & Scapens, 2007).

2.2.4 Performance measurement system

A *performance measurement system* can be defined as the set of metrics used to quantify both the efficiency and effectiveness of actions (Neely, Gregory & Platts, 2005). Ferreira and Otley (2009) have a quite more complicated definition and view a performance measurement system as the evolving formal and informal mechanisms, processes, systems, and networks used by organizations for achieving key objectives. Furthermore, a performance measurement system acts for assisting management and strategic processes through analysis, planning, measurement, control, rewarding, and broadly managing performance, and for supporting and facilitating organizational learning and change (Ferreira & Otley, 2009).

Performance measurement systems is a supporting infrastructure to the organisation (Franco-Santos, Lucianetti & Bourne, 2012). Kraus and Lind (2010) mean that a performance measurement system can contribute to implementation of common visions and strategies throughout the organization, and that the measures should appropriately capture how the firm adds value. Additionally, individual measures should be included. The individual measures can make employees to better understand their contribution to the overall performance, and hence increase their motivation (Franco-Santos, Lucianetti & Bourne, 2012).

However, performance measurement systems do not automatically improve performance only by being applied to the organisation. It is the way these systems are designed, developed and

used that results in a certain performance, and there are several internal and external factors that mediate and/or moderate relationship with performance (Franco-Santos, Lucianetti & Bourne, 2012). Very often, professional judgement needs to be involved to be able to create a performance measurement system that suits the individual organisation, department, or the specific situation (Hopper, Northcott & Scapens, 2007).

2.3 Theoretical framework for analysis

The extended framework by Ferreira and Otley (2009) examines performance management systems in detail (see figure 3 below). The framework has several strengths; it provides a helpful structure for analysing a company's management control system, it considers the operations of the management control system with a comprehensive overview, and it can be used for both for-profit and not-for-profit organizations. The framework was originally developed for only examining private companies, but in Sweden, the government have made efforts to transform the public sector using private sector performance criteria (Lapsley, 2009). Thus, efforts have been made to make the public sector generally more alike private businesses, and to improve its quality and efficiency by using private sector management models (Hood, 1991). Therefore, the framework will yet be applied in an attempt of examining the area of managing the public sector, and hence act as a solid foundation for our theoretical framework for analysis.

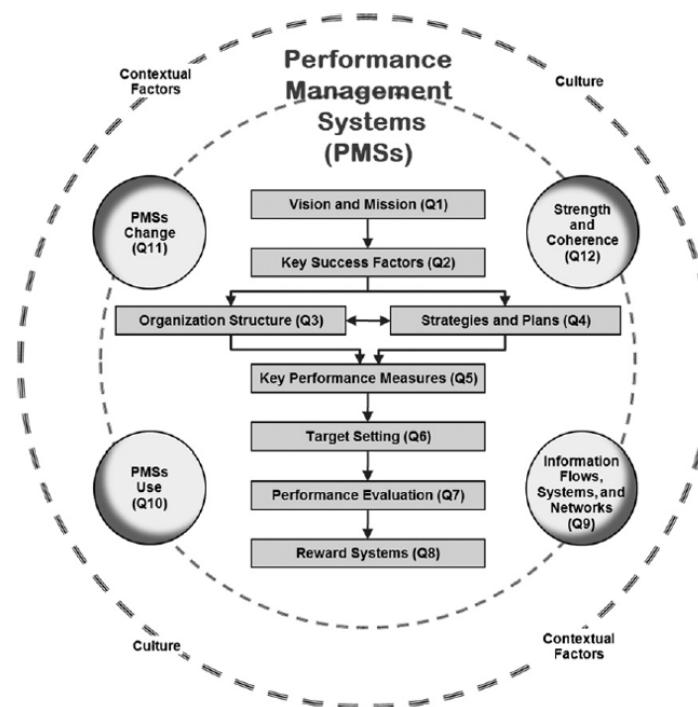


Figure 3. The performance management systems framework

Source: Ferreira and Otley (2009, p.268)

The building blocks of a performance management system are; strategy, financial and non-financial dimensions, achievable targets, and evaluation and rewards that contribute to clarity, motivation and controllability (Hopper, Northcott & Scapens, 2007). Therefore, we will only use parts of Ferreira and Otley's (2009) established framework as a basis for our theoretical framework, and limit it to the four central components; strategies and plans, key performance measures, target setting, and performance evaluation, and regard these as steps in the process of managing an organisation. Since the public sector is rather complex with several external factors affecting the operating organisations, *cultural controls* and *administrative controls* in the framework by Malmi and Brown (2008), act as underlying conditions in the framework.

2.3.1 Strategy and planning

For a performance management system to be relevant in an organisation it requires to support and alignment of the overall strategy of the organisation. Thus, to comprehend and analyse the potential differences in different organisations you need to understand the organisation's underlying strategy (Franco-Santos, Lucianetti & Bourne, 2012). Previous research suggest that managers can use many different management control tools to align employees' behaviour and actions to achieve the intended strategy and plans of the organization (Malmi & Brown, 2008; Simons, 1994; Ahrens & Chapman, 2004). By clarifying the strategy, a firm can identify aspects that drive success, and parts of a performance measurement system can act as a strategy communication device (Kraus & Lind, 2010).

One of the most used tools for planning in the public sector is the budget, which is included as one of the cybernetic controls by Malmi and Brown (2008, see figure 2). Furthermore, the pure planning controls are divided into action planning and long range planning, and they should both set out goals as well as directing effort and behaviour. The long term plans relate to the fulfilment of the organizations' vision and implementing the organizational strategy. Action plans are more short term focused and focuses heavily on tactics. Planning can in many organizations be associated with budgeting, which often is the main management control tool for planning. However, according to Malmi & Brown (2008), planning could also be done without financials, and the budgets is only a way to put numbers on the strategic and operational planning.

2.3.2 Measurement

Key performance measures are used for evaluating an organization's success in achieving its objectives, key success factors, strategies and plans (Ferreira & Otley, 2009). Therefore, performance measures depend directly on which strategy the firm has chosen. Measurement must play an active role in managing the firm to be effective in the chosen strategy (Richard et al. 2009). The measures should be directly linked to the success of the organization, be a part of the strategic implementation process, and align operations with the organisation's strategy (Ferreira & Otley, 2009). However, many companies fail to identify the correct measures for their strategy, and a common mistake is not linking the measures to the intended strategy (Ittner & Larcker, 2003). In the public sector, there is a particularly high demand from the society and the government of measuring performance (Lipsky, 2010), due to it

concerning all citizens, since it is them who pay tax, and it influence the general welfare of the society that they live in.

An organisation should use both external & internal measures, financial and non-financial measures, and make trade-offs between various measures clearly visible (Hopper, Northcott & Scapens, 2007). Malmi and Brown (2008) include measurement in their management control system as a part of the cybernetic controls of the organisation, and divide the measures into financial, non-financial and hybrid measures (see figure 2). Ittner and Larcker (2003) states that focusing on non-financial measures can better show the true value of a company. However, it is a difficult challenge to develop non-financial measures, since they incorporate factors such as quality, service and flexibility which are aspects that are difficult to measure objectively (Hopper, Northcott & Scapens, 2007). Furthermore, non-financial measures tend to be just as easily manipulated as financial measures (Ittner & Larcker, 2003), and financial measures seem to be the more important ones. Kraus and Lind (2010) found that top managers did not believe that non-financial measures were trustworthy at a corporate level. Furthermore, measures of organizational performance can be either objective or subjective, or a mix of both. Subjective measures have been criticized though, because there is too much room for bias. However, both objective and subjective measures have limitations; there is no singular measure that is out of limitations. Additionally, short and medium term measures can be heavily biased by random fluctuations. It is difficult to find an objective way of measuring that not is influenced by external happenings (Richard et al. 2009).

What is measured tends to drive out what is not measured, but as managers have a limited amount of attention, the number of measures is an important aspect to consider. An increased number of measures reduces the significance of each measure (Ferreira & Otley, 2009). Additionally, Lipsky (2010) argues that it is especially difficult to find appropriate performance indicators in the public sector, and contrarily, there is a high demand from both the government and the society of measuring the performance.

2.3.3 Setting targets

A performance measurement system combines different sets of measures to assess how well an organisation meet its targets (Franco-Santos, Lucianetti & Bourne, 2012). Malmi and Brown (2008) argue that planning controls should clarify standard and level of effort, and cybernetic controls should assist in linking behaviour to targets. By measuring performance openly and using targets connected to these, managers' behaviour often changes, especially when linking rewards to the targets (Hopper, Northcott & Scapens, 2007). The use of benchmarking, particularly to external parties, have appeared to provide legitimacy for targets (Spendolini, 1992 in Ferreira & Otley, 2009), especially as shown in the health sector where it is frequently used (Ferreira & Otley, 2009).

Therefore, target setting is a critical aspect of managing performance (Ittner & Larcker, 1998; Ferreira & Otley, 2009), but the process of setting targets usually contains a tension between what is desired and what is feasible (Franco-Santos, Lucianetti & Bourne, 2012). Difficult

target levels have been found to have positive effects on group performance, and it has proven to be desirable for targets to be 80-90 percent achievable. Extensively aggressive targets may be less desirable when cooperation between units is needed since managers may become less willing to compromise (Ferreira & Otley, 2009). A common mistake for non-financial measures is to not set the appropriate performance targets, for example by having targets that give short term financial benefits rather than aiming for a long term profit (Ittner & Larcker, 2003).

2.3.4 Evaluation of performance

To be affective, performance measures needs to be part of a feedback system (Hopper, Northcott & Scapens, 2007), therefore one of the roles a performance measurement system has is to evaluate performance (Franco-Santos, Lucianetti & Bourne, 2012). There is an increased interest in follow-up and evaluation specifically in the public sector, due to recent marketing of the services markets and the so-called audit society. It is however important to note that the interest in evaluation is not limited to only financial monitoring, but has also been influenced by the emergence of non-financial aspects such as a greater focus on quality (Adenfelt et al, 2015).

Performance evaluation is a critical factor of controlling activities, and the routines for evaluation are not always the same as the actual evaluation of performance. Trust between the parties therefore play a major role here, as subordinates' perceptions of the situation can be more important than the formal situation (Ferreira & Otley, 2009). Additionally, the evaluation should appropriately not be limited to financial indicators only, and it is a key skill to understand the interplay between financial and non-financial indicators (Hopper, Northcott & Scapens, 2007). Furthermore, evaluation can contribute to identifying possible needs for changes in strategy, to facilitate comparison with other business units, and to determine the bonus to management and staff (Arwidi & Jönsson, 2010).

Thus, rewards are typically the outcome of performance evaluation. Rewards are considered broadly and may range from expressions of approval by senior management, through financial rewards to long term progression and promotions. Rewards can be based on both individual as well as group performance, which are based on collective achievements (Ferreira & Otley, 2009). If a reward system is needed or which type to choose depends upon how the employees in the organization are motivated. Intrinsically motivated employees are suitably rewarded with non-financial incentives, since they see an inherent value the task in itself. Contrary, employees with extrinsic motivation should have financial rewards, since they have an external drive for performing (Ryan & Deci, 2000). According to Angelis, Glenngård and Jordahl (2016), there is a lot of room for improvement regarding employee questions within Swedish primary care, such as rewarding high performing staff.

Kerr (1995) identified a serious shortage that can be occurring in organisations' evaluation systems, where they rewarded for one behaviour even though the rewarder hopes dearly another. Very often managers will mostly use financial measures to base both their

evaluations and rewards on (Kraus & Lind, 2010). Furthermore, most people search for information concerning what activities that are rewarded and then seek try to do those things, or at least pretend to do them, and often exclude and crowd out activities that not are rewarding (Kerr, 1995). Similarly, Ittner and Larcker (2003) found that instead of focusing on non-financial measures, managers choose and manipulate the measures that made them look good and that could affect their bonuses.

2.4 Analysis model

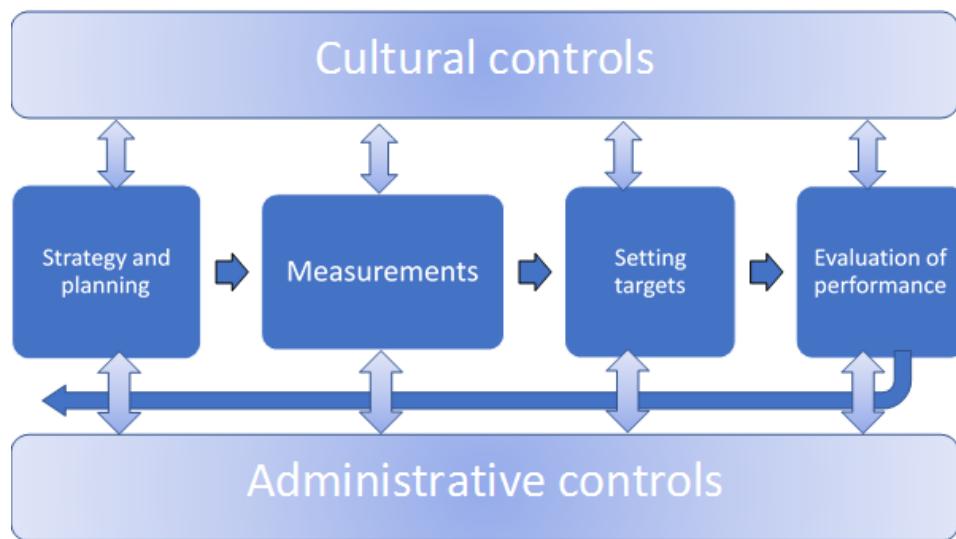


Figure 4. Analysis model, derived from the theoretical framework for analysis

To analyse and interpret our empirical data, we have created an analysis model that is presented above. The model focuses on the four darker boxes in the centre of the model, which represent the four main areas of our theoretical framework for analysis. To understand the public sector and be able to do a relevant and fair comparison of the management control in the different organizations, we see it necessary to understand the context in which the organizations operate. Therefore, we have decided to include the cultural and administrative controls presented by Malmi and Brown (2008) in their theories regarding management control system as a package. By including these underlying controls, the analysis model will be able to provide a more complete understanding of the external factors and the environment in which these providers of primary care operate, and further, how this will affect their management control.

3 Methodology

This chapter provides the reader with a detailed description of the research method and design of the thesis, the motives behind the selected method, as well as limitations of method choices. It explains that the methodology being used in this thesis is an inductive method with a qualitative direction. Additionally, the study has been designed as a multiple case study, which means that the foundation consists of interviews and documents from the three chosen organizations. Finally, research limitations and critique of the study will be explained.

3.1 Research approach

According to Bryman and Bell (2015), a study can have two directions; it can either have a quantitative or qualitative method. Furthermore, they mean that it is helpful to distinguish between qualitative and quantitative studies, even though the distinction sometimes might be ambiguous. Since previous research in this area mostly have focused on quantitative methods, our aim is that this thesis instead will be able to provide a deeper understanding in the chosen topic. As the intention was to investigate the management control in primary care in practice, the research was conducted with a qualitative approach, as we have evaluated it to be the most suitable strategy to fulfil the purpose of this thesis. To have a qualitative approach is an appropriate strategy for generating an in-depth understanding of the situation, and to give a deeper insight in a certain research area (Bryman & Bell, 2015). Therefore, we have used a qualitative research strategy to study management control within primary care and hence answer the research question. The aim of the thesis is to generate a deeper understanding of the studied case companies. Therefore, the used research design in this thesis was a case study, which can be classified as a qualitative approach due to the textual nature of the collected data, as well as the subsequent evaluation (Bryman & Bell, 2015).

Taking an inductive or deductive approach are the two main reasoning methods (Bryman & Bell, 2015). To fulfil the purpose of this thesis, the best approach to investigate management control in organisations within Swedish primary care was to take an inductive approach. The reason for choosing the inductive method is due to the perception that the inductive method, was the best fit for the investigative purpose of the thesis. Furthermore, taking an inductive approach was a consequence of the research in this area being considered rather incomplete, and hence it would be inappropriate to state hypotheses, considering the few studies covering this specific topic. Furthermore, an inductive approach means to make a deeper analysis of single case studies, while starting in specific observations of reality and move to generalisations within a theoretical framework (Bryman & Bell, 2015). Thus, an inductive reasoning method was used, since the aim of the thesis is to create an understanding and curiosity has been driving the entire process. Bryman and Bell (2015) argue that an inductive method is often, but not always, used in combination with a qualitative research strategy.

The research question is focused on generating an understanding of management control within Swedish primary care, and thereafter be able to make comparisons between the chosen cases. Thus, the research was carried out in an explanatory fashion of contemporary events.

Suitable for this certain type of research is case studies, as they aim to deal with operational links rather than with frequencies or incidences (Yin, 2013).

3.2 Research design

3.2.1 Case study

As has been concluded, there are surprisingly few previous studies focusing on generating a deeper understanding the management control in Swedish primary care. Therefore, in order to gain the deep understanding that was aimed at, case studies were selected as research strategy, to be able to understand the actual reality of specific case organisations. Qualitative research alternatives can be carried out in different ways (Bryman & Bell, 2015), but the case study approach was regarded as the most suitable approach as it allows capturing the holistic and meaningful real-life characteristics of organizational and managerial processes (Yin, 2013). This is well aligned with our aim to gain rich descriptions of the management control used, and be able to make comparisons between the different chosen cases. According to Yin (2013), the case study method is highly relevant when a descriptive research question is used, and single surveys should not be used when rich information is needed in the study. Hence, the case study method is considered appropriate in the case of this thesis.

More specifically, the research design chosen to fulfil the purpose of the thesis is a multiple case study of Swedish primary care providers, using qualitative data from several organisations. A multiple case study method can be used when there is a need for understanding complex organisational factors (Yin, 2013). Three case studies have been chosen, to be able to derive rather broad but detailed insights about a management control in Swedish primary care. The case study was performed on one county council and two privately owned companies and only conducted under a short period of time. It is moreover mentioned by Yin (2013) that multiple case studies can be performed during a shorter time period, however the method has been criticized for not showing exact results. However, as Yin (2013) describes, extending the cases to more than one case can improve the quality of the research, and hopefully offer a more nuanced view of the management control in primary care. Furthermore, it is stated that the most common way of collecting information for a case study is by conducting interviews (Yin, 2013).

3.2.2 Selection of cases

The purpose of this thesis is not to make a general contribution of the findings of management control in primary care, but rather to give indications of how it ought to be. Therefore, when selecting the cases to study and gather data from, purposive sampling has been applied, which is a non-probability type of sampling, where the sampling is done in a strategic way (Bryman & Bell, 2015). Furthermore, since the research question gives an indication that a certain category should be sampled, it gives another reason for choosing purposive sampling (Bryman & Bell, 2015).

Of Sweden's 21 county councils a distinction has been made to only focus on the county council in Scania, called Region Skåne, and the 151 primary care centres located in the area, for examination and sampling of cases and interview respondents. The location was narrowed down to this geographical area, due to convenience and the geographic proximity/closeness to Lund University School of Economics and Management.

Furthermore, the study is limited to only investigate three primary care providers within Region Skåne. The research question gives an indication that both actors in the public and private sector, should be investigated. Thus, to fulfil the purpose of the study, three case companies were selected for the study. Therefore, because of the chosen strategy, one public organisation, i.e. the county council Region Skåne was selected, together with two privately owned companies. The criteria the case companies had to fulfil were several, as we wanted their characteristics to be as comparable as possible to each other. In the selection of private companies, they had to fulfil the criteria of having more than one primary care clinic. By choosing to only approach private organisations that has several clinics, it enabled cross comparison with the public county council, as well as in depth study of their documents. The chosen private companies are both for-profit organizations, and this study does not take any private not-for-profit organizations into account. The narrow selection of only choosing two private organizations and one public will give the thesis an indication that can be further developed in more extensive future research.

In order to select specific companies, multiple steps were taken. Firstly, several private primary care organisations were approached via email. The email was sent directly to a relevant member of the management, e.g. the regional or operational manager. The same email was sent to all primary care companies, where we asked to gain access for interviews with representatives from the management team involved in management control. A positive response was received from two companies offering access to one representative each and a contact with them was initiated accordingly.

3.2.3 Company description

It is worth to point out that the interviewee in the first approached case company requested anonymity due to the sensitivity of the information disclosed. Therefore, both private companies were provided anonymity and is not named in this thesis. Rather, they are referred to as Company A and Company B. Therefore, no detailed descriptions of the companies are provided, in order to maintain the anonymity of the companies. However, the public organisation is named and called Region Skåne throughout the paper. Furthermore, none of the interviewees names are mentioned, instead the name of their positions is used.

3.3 Data collection method

3.3.1 Primary data

In order to arrive at reliable conclusions and fulfil the purpose of this thesis, a high amount of primary data was collected. Primary data were collected to increase the level of details, which allowed us to target information directly to the real-related research (Yin, 2013). The primary data was mainly collected through interviews that were relevant to the research topic of this thesis, complying with the purpose. The primary data was also obtained from email correspondence with the chosen interviewees in the three case organisations. In this thesis, semi-structured interviews were used when interviewing several employees within the primary care organisations. Furthermore, two interview techniques were used, namely, semi-structured face-to-face interviews and semi-structured telephone interviews (Bryman & Bell, 2015). Semi-structured interviews are common to use for qualitative studies among other qualitative research methods, and it enabled the researchers to be flexible and intelligent in obtaining information (Bryman & Bell, 2015). The reason why semi-structured interviews were used, instead of structured interviews, was due to the increased freedom when asking questions to the respondents, to thereby gain a deeper understanding of the management control within the specific case companies (Bryman & Bell, 2015). Hence, semi-structured interviews allowed a depth of the study.

To acquire a thorough understanding of the organisations and the management control, we conducted semi-structured interviews with employees in different management positions in each chosen organization. The interviewees were diversified by interviewing managers at different levels in the organisations, in order to understand the different perspectives. It is worth to point out that all the interviewees have solid knowledge in management control within primary care. Where appropriate, we have explained the concepts of management control that is investigated in this thesis for the interviewees. This was done in order to ensure that their comprehension of these concepts is in line with our understanding and to ensure that the different use of terminologies do not affect our results.

The first respondents from the organizations were chosen by the management in the organizations themselves. After initial contact was taken, a recommendation was given on the most appropriate person to interview. This recommendation was based on a description on the subject of the thesis. Some of the interviewees were instead directly approached by us since we found them as suitable participants. In the privately owned primary care providers, one of the managers at the parent company was interviewed, and at Region Skåne, an interview was held with a manager at the county council. To start by interviewing top-managers was done to get a broader perspective and to get an overview of the organisations, and their respective strategy and management control. In addition to interviewing top-managers, similar interviews were held with one managing directors at each of the chosen organisations, in order to diversify the collected primary data and broaden our perspective. These interviewees were contacted via a recommendation from the interviewed manager in the same organisation. This approach gave us direct access and a reliable respondent at the

primary care clinics. However, there is a possible risk for the manager influencing the result of the second interview, since it was provided through them. Furthermore, the possible difference of work chores among the respondents can of course be reflected in the given answers. However, since all respondents are considered be the most suitable to interview in this area, the selection should be considered valid. To complement the interviews, follow up questions were sent via e-mail to the case company representatives were any uncertainties needed to be clarified. See the positons of the respondents in table 1 below.

Table 1. Interview respondents

| | Company A | Company B | Region Skåne |
|----------------------|-------------------|---------------------|--------------------|
| Interviewee 1 | Regional manager | Operational manager | Divisional manager |
| Interviewee 2 | Managing director | Managing director | Managing director |

Since the focus on what to investigate in the beginning of the research was rather clear, a fairly specific list of questions and topics to cover, referred to as interview guide, was created in order to support the semi-structured interviews with the three case organisations. Considering that flexibility was beneficial in order to gain a deep understanding of the management control at the case companies, an interview guide was to prefer over a structured interview schedule, which is normally associated with structured interviews (Bryman & Bell, 2015). The questions in the interview guide were developed based on Ferreira and Otley's framework, and were derived from the thesis developed theoretical framework, and hence split into four areas; strategy and planning, measurement, setting targets, and evaluation of performance. The template for the interview guide is presented in Appendix.

Furthermore, the interview guide was somewhat individualized to each organization, based on their published documents, since to be adaptive is of importance when conducting interviews (Yin, 2013). The respondents were given the areas that the questions would cover in advance, allowing them to prepare their answers a bit and to let them know in what direction the interview is heading, which might have increased the comfortability of the respondents. Furthermore, the interview questions were posed in Swedish during the interviews since all respondents were native Swedish speakers. This, this was done to not miss out on any details or nuances in the answers due to poor communication (Bryman & Bell, 2015). Each interview began with rather open questions regarding the organisation itself, the respondent's background and their current tasks, which is advised by Bryman and Bell (2015). This was done in order to allow the respondent to provide a wide view of the company and their role. Thereafter the rest of the questions in the interview guide were asked, which were divided into the four areas according to our theoretical framework for analysis, to get an image of the management control used in the organisation.

All of the interviews were performed by both researchers in order to support and ask follow-up questions when needed. Thus, both authors participated in all six interviews, in which one

acted as the lead interviewer and the other as support interviewer who had the task of making sure that all information that needed to be obtained was collected. The support interviewer did so by having a detailed interview guide, making sure that all topics had been covered, and this person also took notes. Furthermore, we asked if we could record all interviews, which is recommended (Bryman & Bell, 2015) and all interviewees allowed it, which made it possible to listen through them again and validating the answers. Five of the interviews were performed on location, and one over the phone. This means that different impressions were given both by the respondents as well as the researchers.

3.3.2 Secondary data

As it is recommended to use multiple sources of information (Yin, 2013), secondary data have been collected to support our primary data, which was both useful and less time and resource consuming than collecting primary data (Bryman & Bell, 2015).

The collected secondary data about the case organisations that have been reviewed and analysed have been found on the two private companies' and the county council's websites. In some cases, additional internal documents have been provided by the respondents, in order to complement the information already found.

To gain an overview of the context and legislation of all the primary care centres in Region Skåne we have used *Förfragningsunderlag för Ackreditering och Avtal för Vårdcentraler i Hälsoval Skåne gällande år 2017* (Region Skåne, 2016). The document that has been reviewed is the latest version of the conditions for accreditation. The reason for only examining the most recent version of the document, is that the focus has not been put on the change within the organizations from year to year, but rather on current similarities and differences between the organizations.

3.3.3 Literature review

The literature used in this thesis was found through research on search engines such as LUB Search and Google Scholar, as well as through the general search engine Google. In order to delimit the range of literature and to capture the relevance of it, the researchers looked for keywords such as public sector, Swedish primary care, management control, performance measurement, etc. Relevant scientific articles were found through these search engines, together with by recommendations from our supervisor.

The literature presented in this paper has been thoroughly selected to align with the purpose and problem of this thesis. When conducting the literature review, we began by investigating the theories of management control, strategy and management control systems, which was followed by the concept of performance management systems. Several scientific articles have been used on the theme of management control and performance management systems. The theoretical review is mapping out general theory in the area of management control, which was later used as a foundation and further a detailed description of the theoretical framework, deemed as most relevant for our purpose. Thus, appropriate concepts and theories were central in the selection for the further development of a study. The theories were selected in

order to be able to create a theoretical framework that could be used for analysing the empirical material, and thereby understand the findings from a theoretical point of view and hence fulfil the purpose of the thesis.

3.4 Data analysis

In order to be able to draw any conclusions from this study, the data collected was also analysed. The empirical analysis was done by comparing and analysing the empirical findings, both primary and secondary data, by first comparing the three different primary care providers to each other. Thereafter our theoretical framework for analysis was used to relate the findings to literature. The framework was presented in the previous chapter, where it was delimited and refined according to the peculiarities of the public sector. Finally, the findings were discussed by putting them in relation to the public sector context where the studied organisations act.

Since the interviews were both recorded and notes were taken, the researchers could go back and forth between the interview material and the result, creating an iterative process in the analysis. Both of the two researchers analysed the material so that the conclusions made could be considered valid, which also decrease the confirmability of the individual researchers.

3.5 Research criteria

3.5.1 Validity

This thesis took an inductive approach to fulfil the purpose of the study and when constructing the interview guide, careful attention was paid in order to maximise the internal validity of the study. According to Bryman and Bell (2015), this ensures high level of congruence between observations and concepts that strengthen the research in the interviews. Moreover, the fact that employees in different hierarchical levels were interviewed increased the validity of the study. Another limitation of the study is inconsistency concerning the interviews. The best way would probably be if all interviews had been conducted the same way. Furthermore, when conducting our cross-case comparisons it was important to keep in mind that the representatives from the three case companies are not holding the exact same positions. The comparability of the primary data collected from these individuals can therefore be negatively affected, in the sense that they may not be derived from differences in the case companies but rather by differences in perspectives due to their different roles. The collection of data has therefore been collected with an emphasis on specific questions regarding the organisation's use of different types of management control, with the aim of not directly targeting the respondents' internal position.

External validity concerns whether the study's results can be generalized or not (Yin, 2013), and due to the in-depth nature of case studies such as this thesis, with low numbers of cases,

the results may not be generally applicable to other organizations. Additionally, purposive sampling makes it impossible to generalize the results to the entire population. Our research is conducted in Swedish primary care and public sector, which has some rather unique characteristics and regulations, which could negatively affect generalizations on organizations outside of this sector. Therefore, the results are rather context dependent which limits the transferability of the study. However, our aim is not to offer an all-covering description of management control within Swedish primary care, but rather to highlight parts of it and generate an understanding. We therefore believe that the empirical findings from this case study still will be useful in broadening the collective knowledge base in the field, despite the lack of ability to generalize our findings.

Furthermore, the external validity is quite limited considering that only three companies in one rather specific context, primary care in Region Skåne, have been studied (Bryman & Bell, 2015). If organisations within primary care all over the country were selected as cases, perhaps the result would have been different, and it would have been desirable if the empirical material were collected from a larger sample. Furthermore, we have used multiple sources in our research, using both interviews and secondary data. However, we have only obtained primary data from only two representatives in each case company, one at each level in the organisation, which can possibly affect the validity negatively making the individuals' subjectivity a significant factor. Thus, this approach make the results of the study heavily dependable on each of the conducted interviews. Hence, in order to allow for generalisability of our study it would have been beneficial to include more case companies as well as having interviewed additional employees in each organisation. Instead, this study has given an indication of how management control is being used in the public sector context, and more specifically within primary care.

3.5.2 Reliability

To assure reliability and decrease the dependability of the study (Bryman & Bell, 2015), we have recorded all interviews and e-mailed follow-up questions when uncertainty arose when interpreting the data from the representatives. Thus, allowing the researchers to go through the material several times, in order to receive and present a fair view of what has been said. Additionally, the documents were first investigated alone by each researcher and then discussed. This allowed the researchers to receive an opinion of their own, before discussing and analysing the material. This approach, together with providing anonymity to the case companies will also make the study more credible (Bryman & Bell, 2015).

3.5.3 Replicability

The replicability of this study is rather low considering that semi-structured interviews were conducted where the questions were adapted to the cases and to the answers provided by the respondents. Furthermore, it is difficult to achieve replicability in a qualitative study, since it is impossible to freeze a social setting (Bryman & Bell, 2015). Nevertheless, by publishing the interview guide (see Appendix) it improves the ability to replicate the study.

Moreover, due to the sensitivity of the information provided by the companies, anonymity was provided to both companies, which limits the replicability. However, notes were taken during the interviews and the interviews were recorded, but only for the researchers own sake. Hence, the anonymity of the chosen companies makes it impossible to use the same respondents in another study performed by different researchers. Thus, even with the same research design and similar cases, they would most likely arrive at different results and conclusions (Bryman & Bell, 2015).

4 Empirical findings

This chapter presents the empirical foundation of the study. Primary and secondary data has been gathered from three primary care providers within Region Skåne, whereof two are privately owned companies and one is owned by the county council. The chapter starts with a description of the conditions specific to Region Skåne. It is followed by a presentation of the data from each of the three primary care providers, divided into the four components of the framework for analysis.

In Region Skåne, the primary care providers get payment from the county council, based on the enrolment of patients and the characteristics of those patients in form of *Adjusted Clinical Groups* (ACG) and *Care Need Index* (CNI). ACG describes the patient's expected need for care based on their diagnoses, adjusted with age and gender. CNI is used for assessing the expected risk of illness based on seven socioeconomic factors: unemployment, several children under 5 years, born outside of EU, single with children under 17 years, single over 65 years, having moved within the last year, and low degree of education (Angelis, Glenngård & Jordahl, 2016). Additionally, every year the county councils sets conditions for accreditation regarding what the primary care in the region should include, which the primary care providers must follow and adjust their operations against. The conditions for accreditation are presented in late November/early December, and thereafter must be applied by the start of the following year (Region Skåne, 2016). The contract with conditions for accreditation is signed between the contract manager at Region Skåne and the managing director at each primary care centre. The contract is then formally valid for two years, but if the providers meet the requirements for accreditation, it is automatically renewed (Angelis, Glenngård & Jordahl, 2016).

4.1 Company A

The first private organisation studied is, according to their webpage, an international organization with more than eighty primary care centres in Sweden. The company focuses on different areas within healthcare and in addition to primary care centres, they offer specialist care and hospital care. The company was founded in the middle of the 1990s and have grown by mainly acquisitions of other healthcare companies.

4.1.1 Strategy and planning

The vision and strategy of Company A is to achieve the best possible quality of life for each patient and their values is based on the three words: *quality, compassion and responsibility*.

The planning process at Company A is divided into two different areas. The management use a yearly budget for short term planning for the upcoming year, and a business plan to make long term plans for a four to five years' future. Furthermore, the unique characteristics of their budgeting process, the respondents mean, is that the entire revenue is depended on external factors in terms of the contract with conditions for accreditations which is created by

the county council. Since the contract is unique for each county council which consequently leads to that the company needs to adapt their budget and operations for each county council in which they provide their service. According to the regional manager the budgeting process is mostly managed by the management at regional and top level, but the managing directors at the primary care centres are able to comment and are somewhat included in the process, but the final decision is made by top management. Both the regional manager and the managing director seemed to agree on that once the budget is set, the managing directors have high autonomy to by themselves plan and decide on how to reach the budget's goals. Furthermore, since the conditions for accreditation usually is set in late November and therefore, at the end of the company's budgeting process the regional manager describe this as the time to adapt to the new conditions of the agreement. There was currently a dialog between the managers at the company and the politicians about this issue, but no real change or solution had been presented.

According to both the webpage and the regional manager, Company A have developed their own business model based on the vision (see figure 5 below), which includes the company's entire business and is based on their three founding values.

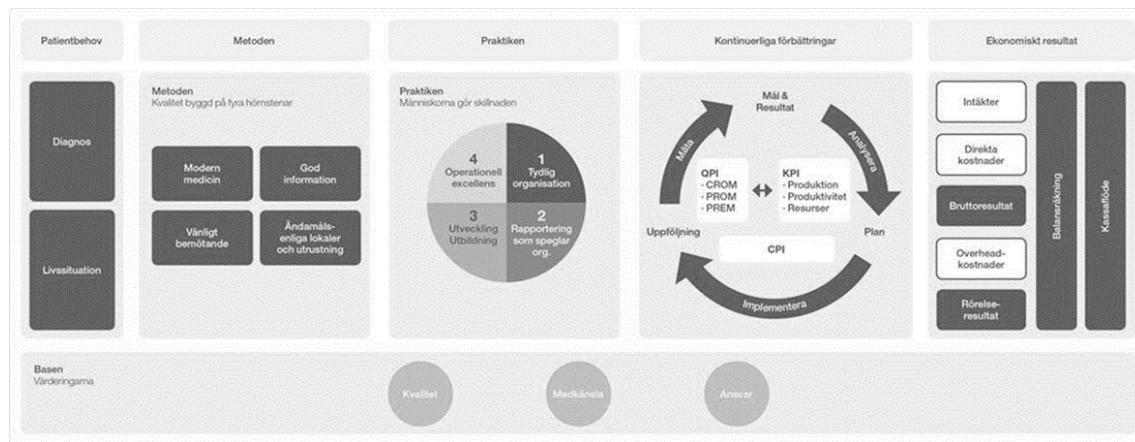


Figure 5. Company A's business model

One thing that was emphasised from the regional manager was that quality is the main driver of the financials and economy of the organization. This could also be observed in their model where the base of the model begins with the patients and how to assure quality and then it ends in the financials. Further, two overall themes of the internal structure of the organisation was mentioned in the interviews, the first one was that the managing directors have a lot of autonomy in their work and the second was that the organization had a strict and clear hierachal structure with instructions of responsibility and communication. The organization have three different levels of managers, the top management which includes the CEO, CFO, etc. The second level consists of regional and business area managers and the last level is the managing directors at each of the different primary care clinics. The regional manager explained that in the position it's important to communicate and to transfer knowledge and information from top management to the managing directors to ensure that everyone works

toward the same goals. One of the advantages of the clear hierachal structure according to the managing director is that the role clarification and the responsibilities becomes easier identify and that you always know who to contact and talk to. A problem that the managing director had observed previously while working at a public primary care clinic was that they had very long decision paths, and sometimes they were omitted and worked all by yourself, whereas at this company they had daily contact and dialogs with their managers.

The business plan is created for each individual primary care centre and describes how the business and organization will operate for the next four to five years. According to the managing director they had a lot of freedom while drafting the business plan, but some directives are made from the top of the organization. The business plan is when completed, communicated to the employees at the primary care centres by the management both through meetings and by weekly updates at the company's internal webpage. The workplace meetings in combination of the internal webpage together with a weekly letter was the primary communication channels that was used in the organization.

4.1.2 Measurements

Measurements is another topic that is included in Company A's business model (see figure 5). The measures are divided into distinct categories and the main focuses according to the regional manager is the KPIs and QPIs. According to the company's webpage, the QPIs stands for quality performance indicators and includes measures such as CROM, PROM and PREM. The second types of measures are the KPIs which measures production, productivity and resources. The regional manager explained this as "*We measure medical quality to ensure good healthcare to make the business work, and KPIs to improve and work smarter*". Yet, another measure with high importance in the organization is the Adjusted Clinical Group (ACG), since it is used to calculate the payment to the primary care centres. Since this measure decides 80 percent of the payment, the managing director emphasised the importance of measuring and updating this measure frequently. In addition to the QPIs and KPIs, Company A also focuses on employee measures to ensure that the employees are satisfied, which is mostly relevant at an operational level at the clinics where employee evaluations are used. The measures are set by managers within the organization itself and is not affected by any external pressure. As told by the regional manager: "*The county council does not demand any measures. They have ordered our healthcare service, but how we provide this service is up to us*". The managing director further explained that many of the general measures comes from the medical officer (which is a part of the top management team of the organization) but that each managing director have some freedom in what to measure, as long as its relevant for the organization.

A general trend from the interviews is that the managing director tended to focus more on non-financial measures and when asked which kind of measures they use, focused on the QPIs and more practical measures such as patients' blood pressure and patients' satisfaction-rate. The managing director was aware of and worked according to the budget, but was not as involved in the decisions regarding the financial measures and was not aware about the term

KPIs. The regional manager had a more balanced view of the financial and non-financial measures and the linkage between them, furthermore the regional manager explained that one of the main tasks is to inform and educate the managing directors regarding the financial mind set, since they usually were very knowledgeable in the practical areas but could have a lack of experience regarding the financial areas. Both interviewees mentioned that even though a lot of emphasis is put on the quality measures, in the end it is a lot of focus on the financial measures and reaching the budget.

Both the managing director and the regional manager mentioned that some measures was highly depending on external factors and was as a result hard to work with. One of these measures mentioned by both participants was the cover ratio. This measure is included in the contract with conditions for accreditation from the county council, and describes the ratio to which the patients will go to the clinic where they are enrolled. If the ratio is lower than a pre-decided limit the company needs to repay the county council.

4.1.3 Setting targets

The overall vision and long term target of the organisation is, as mentioned earlier, to offer the best achievable quality of life for every patient and according to the regional manager to be the number one choice for the patients and employees and further refers to the saying that "*it's quality that drives the economy*". One of the biggest targets of the company is to reach the annual budget which makes reaching the budget for the primary care clinics important since they are paying for the overhead cost of management and support functions. Both the interviewees mention that it is a lot of focus on the financial targets in the organization, which the regional manager considers to be natural in this kind of company. The managing director agrees, and state that it is a lot of focus on the economy and on the financial targets, which is rather hard to reach. These targets move through the organization, where the top managers put pressure on the regional manager which in turn set targets on the managing director and so on. The regional manager explained that depending on the type of target will decide if it should be used more as a visionary target to reach for, or a target which is expected to be reached each year. The managing director further mentions that the financial targets for each year generally is hard to reach but that they had managed to get closer to their financial targets and exceeded those for the previous month. Furthermore, most of the overall targets and budgeting targets are as mentioned above set by top management, whereas the some of the more clinic-specific targets are set by the managing directors' management team to enable them to affect certain areas in which they mean that the clinic should have its focus.

While some targets have a more visionary purpose to guide the organization in the right direction and you follow the progress and trends towards the targets, other targets are stricter and should be reached for each year. The managing director answered that similar to the measures, most of the targets are set by the top management of the organisation and then communicated down to the managing director by the regional manager through the budget and monthly meetings. The managing director also gave a recent example regarding a target

to have a 100 percent coverage of all the phone calls. This target was more of a visionary target and was not expected to be reached but still the managing director with employees managed to reach the target.

Company A tries to balance the long and short term mind set of the organization by using both the yearly budget in combination with the business plan. With a longer horizon and focus from the business plan, the yearly budget will rather focus on the annual targets and be more action orientated whereas the targets in the business plan will focus on long term targets and the direction of the business. The regional manager often referred to their business model (see figure 5) and the fact that the economy is depending on the quality of the service which tries to put emphasis on the long term benefits of the organization. Further, this is aligned with the vision of the company; to create the best life quality for the patients.

4.1.4 Evaluation of performance

Each primary care centre is evaluated on a monthly basis where they have a monthly closing which is reported up to the regional manager. The regional manager will then visit each of the centres to discuss and evaluate the performance and potential actions in regard to the result. The regional managers mentioned the importance of internal benchmarking between both separate clinics and time periods, the comparison is made through a reporting system called Medrave. The managing director mentioned that during the monthly evaluations there is mostly focus and discussions regarding the financial targets and that the QPIs do not get the same attention and are not evaluated or discussed as often. According to the managing director, this was a shame since those were the measures that they worked most to improve and could really influence at the clinical level. In addition to the meeting with the regional manager, the managing director have a meeting with the management group of the primary care centre where they evaluate the performance and informs the employees about the performance through a monthly letter and updates on the internal webpage. The monthly performance evaluates the entire operations of the company and the individual clinics as a whole. The managing director further explains that the individual performance usually is evaluated during the annual salary discussion, where better performance will result in a higher raise in salary.

When interviewing both the participants regarding rewards, both the managing director and the regional manager seemed to agree that the main focus and the most important part of the incentives in the organisation came in shapes of non-financial incentives such as feedback and acknowledgement of good performance. However, regarding financial rewards their answers differed a bit. The regional manager explained that financial incentives had been used during certain periods of time but that it had not been used in recent years due to a harsher business climate. Whereas the managing director mentioned that the managers had a bonus if they reached a financial surplus from the budgeting target. Similar to the regional manager the managing director said that the focus of the incentives in the organization was feedback and some social event or having cake. Furthermore, neither the regional manager nor managing director was aware of any consequences or sanctions for not reaching a specific

target but each manager had to explain their performance in their evaluation in the end of the year. Based on this a plan is created between of how to improve the performance and hopefully be able to change the trend to the right direction. However, the regional manager continued and mentioned that if you see a negative trend and bad performance from a managing director for a long period of time, then it might become relevant to think of a solution and if the manager is right for the job.

4.1.5 Summary

Table 2. Summary Company A

| | | | | | |
|----------------------------------|--|--|--|--|---|
| Strategy and planning | “Best possible life quality of life for each patient” - Quality -Compassion -Responsibility | Have created their own business model | Yearly budget based on conditions for accreditation | Business plan 4-5 years ahead, which is drafted by managing director | Budgeting is done by top management, managing directors have some involvement |
| Measurements | Both KPIs and QPIs -CROM -PROM -PREM -ACG | Measures decided by management, but managing directors can decide some measures themselves | More focus and involvement in the QPIs at clinical level | More balanced view of both financial and non-financial at top management level | A higher focus on financial measures compared to non-financial |
| Setting targets | Based on the annual budget set by top management | Managing directors are able to set additional targets for their clinic | High focus on financial targets, but emphasizes the importance of non-financial ones | Combination of visionary and concrete targets, and long and short term targets | |
| Evaluation of performance | Evaluation of each clinic monthly | Internal benchmarking | Evaluation on group and clinical level monthly (individual annually) | Focus on non-financial incentives | Have used some financial incentives (bonus for managers) |

4.2 Company B

According to their website, Company B is a family owned Swedish company that was founded as a reaction to the healthcare reform, which they mean gives advantages to smaller healthcare companies but made it harder for individual clinics due to the increased demand on administrative part of the operations. The organization consists of approximately 15 different primary care clinics operating in various geographical locations in Sweden, but with a majority of its clinics in the southern part. The individual clinics within the company keep their original names and their local connection, which is an important part of company's strategy and vision. Many of the clinics has operated for more than twenty years which enables them to provide better quality, service and continuity and this is also the business idea of the company.

4.2.1 Strategy and planning

In addition to the business idea the company have a vision and strategy based on three cornerstones which guides all operations and decisions of the organisation. The three cornerstones are *long term focus, local attachments and centralized resources*.

The company is divided into three different managerial levels and the organization is structured to be agile and adaptable to sudden changes. As explained by the operational manager “*a part of our strategy is to, in contrast to the public and county council owned primary care clinics, which we often compete with, have short decision paths and be able to drive the company forward and have a dynamic primary care*”. The operational manager further explained that one action to obtaining this, is to have a small management team consisting of four persons whom all can discuss and make strategic decisions. The highest management level consists of the CEO, CFO, the operational manager and a business developer. The second level is the operative management team which includes all the managing directors at the primary care centres, the operational manager and the business developer. The last managerial level is the managing director at each local primary care clinic, which, depending on the size and needs of the clinic, have their own management team.

To further align the operations with the strategy and agile decision-making, each managing director have a high amount of autonomy and can make a lot of the operational decisions by themselves. The managing director had a similar view of this and agreed on that focus could be held on quality and the practical issues regarding the business, as the management team focused on the more administrative part. Furthermore, to enable the managing director to focus on the practical planning and assure the quality a majority of the administrative and financial tasks have been lifted from each individual clinic to the top management, which have specialized on understanding the contract with conditions for accreditation and how to plan and adapt to these changes. The management will then work as a supportive unit for all the individual primary care clinics.

The operational manager mentioned that the direction of the organization was continuously discussed between the top management and the owners. Furthermore, a part of their long term strategy was to grow by acquiring other primary care providers and not by growing organically.

The main planning tool of Company B is focused around the budget and the budgeting process, which begins in the autumn. The operational manager describes that, during this process the main objective is to try to understand in which direction the politicians for all the county councils wants to change or steer the primary care by changing the conditions for accreditation from previous years. Once the new contracts have been sent out in late November or early December, the management will finalize the budget for the next year, and the individual clinics will receive their budget. Most of the budgeting process and its decisions are taking place at the top management level, but with some input and dialog with the managing directors. The operational manager explains this with that since the management is more knowledgeable regarding the conditions for accreditation and the company's financials it is better if they handle the budget, which results in that the budgeting process have a top-down approach. The managing director have a similar view of this and mentions that the budget is created by top management and handed down to them, so that they instead can focus on planning the practical tasks at the clinical level with the budget as a framework. The operational manager further explained that before becoming a manager at Company B he worked within healthcare at Region Skåne where there was an experienced tendency of pushing a lot of administrative work downwards in the organization towards the employees that worked closest to the patients. This was according to the operational manager a way to control the employees, whereas at Company B the management works as a support function to help and enable the employees at the primary care centres.

The planning and strategy of the organization is communicated down in the organization by meetings between the operational manager and the managing directors. In the end of the budgeting process there is a meeting where the managing director is informed by the new budget which will be the base for the next coming years operations. The managing director in turn have monthly workplace and staff meetings, which purpose is to both inform the employees of the new directives and evaluates the previous months' performance. However, the managing director mentions that it is sometimes hard since there is always a demand for more resources to be able to hire more employees and help even more patients, but that cannot be done since the financials needs to add up.

4.2.2 Measurements

Since a core concept of Company B is to remove a lot of the administrative burden from the individual clinics the decision of what measurements to use is made at the top management level. The operational manager explains that the measurements are decided based on what the county council communicates through the contract with conditions for accreditation, and that the KPIs can differ depending on which county council the clinic operates within. Some county council have a more cost focus regarding their primary care, whereas some focuses on

both revenue and cost and another can focus on other measures such as the ACG or certain actions such as home visits to the patients. The operational manager continues by explaining the importance of understanding that in the end their only customer is the county council, and states that "*the employees will of course help the patients as much as possible, but it must be within the agreement of how to county council wants the care to be provided*". The managing director mentioned that they have little contact with the county council, since most of the measures are decided at management level. However, as explained by the operational manager, the measures are based on the conditions for accreditation and therefore highly affected by the county council.

The operational manger seemed to have a balanced view over both financial and non-financial measures. Whereas the managing director talked more about measures related to operations such as numbers of home visits and coverage ratio of their patients. The managing director mentioned that these measures was important since they affected the revenue and the economy but the managing director had not been involved in the decision of what to measure.

The operational manager further explained that for the measures to be effective they need to be relevant for the organizations business. Even though some measures could be interesting it is always a question of how much of the management's resources that should be spent on each measure and what value the measures will contribute to the organization. Since the targets of the organization needs to be able to be reliable the operational manager mentioned that the measures need to be both quantifiable and objective. Further, the managing director discussed the problem with subjective measures in the primary care. Since they work with individual people it's hard to standardize some measures and with measures such as patient-satisfaction different patient can react differently to the same service. The managing director explains it as, even if a patient has got the best possible care, they could still be unsatisfied and a satisfied patient doesn't automatically determine high quality in the care. The managing director further remarked that some measures, such as the cover ratio of the patients, was hard to really affect since it depended so heavily on external factors.

4.2.3 Setting targets

Similar to the measures, the general targets of the company and for the individual clinics are set by top management. The operational manager explained it as, "*top management will create the main targets for a clinic, let's say target 1 to 6. The managing director will then be able to set their own targets 6 to 10 as long as they align with the first targets and the overall strategy of the organization*". The managing director did not seem to mind about not being that much involved in the targeting process and the financial process, because this freed up time to focus on quality and practical matters regarding the clinic. The targets are usually based on previous performance and benchmarking between the clinics and county councils. Most of the targets are decided together with the owner, but the operational manager described it as "*since the company is family owned we don't have that much pressure on short term financial targets but can focus more on continuity of the business*". Furthermore, both the operational manager and the managing director agreed on that the targets should be

relevant and reachable for them to be useful in the organization. Even though they both agreed on this, the operational manager explained it more as a way to create continuity between managers and employees and more in the sense that the goals should be reachable to not put unnecessary pressure in a knowledge based organization. Whereas the managing director explained more like the targets are set by the managers with the expectation that the clinics will reach them, no more no less.

As mentioned above, the fact that Company B is a family business will according to the operational manager allow the organization to have a long term focus in their operations and do not require them to set short term targets to maximize profits. Despite this most of the targets that is mentioned by the interviewees seem to be based on yearly performance, but the operational manager mentions that even though the targets are based on yearly performance they tend to focus on the trend and benchmark the performance over-time rather than just at separate occasions.

4.2.4 Evaluation of performance

Company B uses an ongoing evaluation process with weekly updates of the performance and phone meetings between the operational manager and managing director every other week. The operational manager explains the purpose of the ongoing evaluation is to identify trends to be able and quickly adjust and adopt certain actions to counteract negative tendencies. To complement the weekly check of the KPIs there is a larger monthly evaluation where they assess the performance against the budget. At the managing director's primary care centre, they held a weekly staff meeting where the managing director informed the employees about the performance and how to proceed and reach the targets. In addition to the common staff meeting each separate groups of employees for example doctors and nurses have their own meeting to evaluate performance.

One of the most used tools for evaluation in Company B is, according to the operational manager, benchmarking. The management uses benchmarking both internally between the different clinics but also historically for the organization and the different units. The company additionally started a collaboration with other private organization in the primary care sector as well. By benchmarking with each other and communicating and sharing knowledge the relationship is beneficial for all participants. When asked if they benchmark against public primary care providers as well, the operational manager replied that they do not benchmark against the public ones since they know that they are better than them. The operational manager explains this statement by meaning that the public primary care has problems with being agile and adaptable. Since implementing changes is very important for Company B, this limit the usefulness of benchmarking towards them. Related to the fact that the operational manager had experienced a lack of flexibility in the previous public organization, there seemed to be a financial problem where primary care providers showed negative financial results for a long period of time, which is something that is not an alternative for a private organization.

The evaluation on the top management level will mostly focus the performance of the organization as a whole, and then the individual clinics. At the separate clinic, each managing director can to some extent decide how to evaluate their performance. The participating managing director explained that they used evaluations on group level with different groups of employees, which works as a peer evaluation of the colleges, and also to spread the knowledge and experience between the employees. In addition to the group evaluations each employee has an individual meeting twice a year. During this meeting, the performance of the employee is evaluated and new targets and goals is decided for the next six months.

To be able to evaluate performance fairly and consistently the operational manager further referred to the importance of having clear and relevant measures and targets which could be understood and accepted by the people of the organization. To achieve this acceptance the evaluation is based on objective and measurable targets based on the conditions for accreditation. According to the managing director, the evaluation could sometimes be hard, even though the targets and measures are objective and quantifiable since the primary care centre works with people where performance and quality can be based on feeling and other factors that is hard to measure. Another factor which can complicate the evaluation is that there is a lot of external factors that affect the performance and comparability between different clinics. Some examples given by the managing director is the location of the clinic and the age and requirement of the patients.

When asked about performance related rewards the operational managers did not want to comment but the managing director mentioned that they did not use any financial incentives to reward performance. Instead they focused on non-financial incentives and feedback. The managing director explained that the employees at the clinic was intrinsically motivated with high morale and work ethics, so there was no real need for a financial reward. Instead they focused a lot on acknowledgement of satisfactory performance and social event such as having cake to celebrate and reward good performance. Furthermore, one factor that the managing director mentioned that sometimes could have a somewhat negative effect on the motivation at the clinic, is the non-existing incentives of creating a surplus in the operations during one year. The surplus or exceeding the budget targets is centralised and transferred into the whole company, and is then reset for the next year and a totally new budget is created. Thus, there is no real gain for a clinic to aim over the budget targets, which probably lowers the motivation to perform once the targets are reached. However, there is no real punishment for not reaching a certain target either. Instead you looked at the trend and tried to work together to improve or change the trend. The operational manager described it as since they wanted to work with a long term approach there was no idea to be too harsh and rather focus on continuity in the organization. However, if a managing director would perform poorly over a long period of time, he or she would indirectly receive more pressure since the operational manager would focus more attention towards that primary care centre to try to change the trend.

4.2.5 Summary

Table 3. Summary Company B

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|----------------------------------|--|--|---|---|---|
| Strategy and planning | Cornerstones: - Long term focus - Local attachments - Centralized resources | Centralized administrative tasks to top management | Yearly budget based on the conditions for accreditation | Continuous dialog with owners and growth by acquisition | Budget communicated to each managing director |
| Measurements | KPIs vary depending on the conditions for accreditation and the county council | Measures used: - ACG - Number of home visits - Coverage ratio | Measures decided by top management | More balanced view of both financial and non-financial measures at management level | A higher focus regarding the financial measures compared to non-financial |
| Setting targets | Targets are based on the annual budget set by top management | Managing directors are able to set additional targets for their clinic | Targets are set to be reachable, and relevant | Combination of long term and short term targets | Targets and measures should be objective |
| Evaluation of performance | Evaluation of each clinics occurs weekly | Internal and external benchmarking | | Focus on non-financial incentives | No mentioning of any financial rewards |

4.3 Region Skåne

Region Skåne, the county council in Scania, is responsible for the service of primary care and operates approximately 85 centres for primary care. Even though the public primary care providers within Region Skåne in theory operates under the county council, they should operate with the same conditions as the private primary care providers. Important to notice is that the participating managers in this thesis belong to one of the five divisions in Region Skåne, so when we refer to Region Skåne we refer to this division.

4.3.1 Strategy and planning

The divisional manager at Region Skåne stated that the main purpose of the primary care is to be the first line of healthcare provided to the citizens that do not require hospital care which is set in the law. However, there is no concrete definition of what the primary care should

include and no overall strategy of how the primary care should be managed on national nor regional level. The divisional manager further explains that since the healthcare often is decided at a political level there is often many changes in policies which makes it harder to implement and follow long term strategies.

The planning process is based on a yearly budget. The budgeting process for the coming year will begin in the autumn of the current year, but cannot be finalized until the conditions for accreditation has been finished, which according to the divisional manager will make it very hard to adapt to the new conditions before the new year begins. This results in a lag in the next year before the changes have been implemented at each primary care clinic. The budgeting process will both take place at the top management level of Region Skåne where the overall budget for the organization will be planned by the divisional manager and the management group. But in addition to this the managing director is responsible for creating a budget and plan for their own clinic. The participating managing director at Region Skåne mentions that the amount of autonomy could vary for each clinic depending on the previous performance. Where the low performing clinics tend to receive more focus and involvement from the top management. The managing director will during the budgeting process be supported by an economist working at Region Skåne and will base the budget on estimates from the result from previous years, until they receive the conditions for accreditation for the next year. In addition to the budgeting processes, the divisional manager and managing director describes two other tools for obtaining the strategy and managing the operations. The first one was which is presented visually as a flower with five areas regarding economy, employees, quality, future innovations, and availability in time and place. This tool was used for creating some sort of long range plan and guidelines for the development of the primary care. The work within these areas should be guided by the beliefs of being driving, welcoming, respectful, and caring. The second tool that was mentioned was the balanced scorecard to plan and keep track of certain key measures and benchmark the performance of the clinics. Furthermore, the participating managing director have implemented a tool where each employee at the clinic can add their own ideas and goals for the clinic continuously in addition to the targets that is decided in the budget. The tools are added on a whiteboard that is discussed during a weekly meeting. By using this tool, the managing director explains that you can both involve the employees in the planning and target setting process but also get ideas of the people working close to the patients that have input on ways to improve the operations.

Once a proposal for a budget has been made for the overall division it will go on a remiss to the different parts of the organizations. The divisional manager argued that the reason for the remiss is to increase the participation and knowledge in the organization. The managing directors are then allowed to have inputs and give feedback on the proposal until its finally decided by the divisional manager. At the individual clinic, the budget is discussed in a meeting with one union representative for each group of the employees, for example nurses and doctors. After the budget has been accepted the managing director have a larger meeting

where all the employees are informed about the budget. Further, an aggravating factor in planning and strategy is according to the divisional manager that each clinic should carry its own cost and work with its own budget based on the terms in the contract with conditions for accreditation, and the overall surplus should cover the overhead costs of the organization. However, since many of the clinics struggle to the financial measures in the budget the overall result is negative. This will also prevent the clinics that exceeds their budget to reinvest that money since it is needed for the overhead costs and to cover the negative overall result. The managing director continuous with this reasoning and mentions that this can have a negative effect on the employees' motivation at the clinics, since the high financial performance gain the operations and their ability to treat patients.

4.3.2 Measurements

The main measures that is used at Region Skåne is included in their balanced scorecard, which consists of ten measures that is used to track the operations at each individual primary care centre in this division at Region Skåne. Of these ten measures, nine of them focus on non-financial results related to the operations, for example compliance with the hygiene and dress code at the clinics, the usage of antibiotics, home visits and phone coverage. The last of the measures is the only financial one and keeps track of how the clinics perform financially compared to their budget. See all measures below.

Table 4. Measures included in the balanced scorecard at Region Skåne

| |
|---|
| 1. Basal hygiene and cloth routines |
| 2. Amount of antibiotics prescribed |
| 3. Living habits (e.g. nicotine meetings) |
| 4. Phone availability (coverage) |
| 5. Number of home visits |
| 6. SIP coordinated individual plan |
| 7. FAS (diagnosis of patients) |
| 8. Sick leave of staff (below 28 days) |
| 9. Sick leave of staff (above 28 days) |
| 10. Financials compared to the budget |

These measures are decided by the divisional manager and the other managers, but are affected by policies decided by the politicians. They are later evaluated by higher instances in the county council, but it's up the divisional manager of what to measure and which measures to focus on. Furthermore, the divisional manager explained that since the nature of their organization is to treat people and improve the health of the citizens the focus tends to be on the non-financial measures. However, in regard to the current economic situation a lot of focus tend to be on the financials anyway, which the divisional manager find unfortunate but

understandable since it is the usage of tax-money. Supplementary to the measurements in the balance scorecard the managing director can implement their own measures. One example of these measures that the managing director had decided to focus on is the amount of home visits to the patients.

The divisional manager also mentioned that there could be some problems to discuss financial measures in the organization since the concept of money tends to be rather abstract in a not-for-profit organization. One reason for this was that the financial results had very small actual impact on the operations. Especially in some areas or locations where the public clinic is the only provider of primary care and could therefore never be shut down. The divisional manager continues that the public primary care provider is a hybrid between a traditional company and a public organization, where they should cover their own costs but are currently not allowed to use their potential profits and cannot go into bankruptcy. This puts the public primary care providers somewhere stuck in the middle, which the divisional manager describes as "*pretending to be a company*". The political management of the public primary care will, as stated by the divisional manager, often make their decision processes longer and they have also stricter legislations which limits how they will approach certain processes. An example given by the divisional manager is that if the public primary care wants to change suppliers they must go through a long bureaucratic process that can take years. Whereas a private actor with some financial power can have it done quickly. Despite the hardship regarding financial measures in a public organization the managing director or at Region Skåne was highly involved and knowledgeable in both the financial and non-financial measures and the interaction of the two measures. Furthermore, regarding financial and non-financial measures, the managing director mentions that a lot of the measures work as a hybrid, where the measures themselves are non-financial but they will directly affect the economy of the clinic. Some examples of this is the number of home visits, where each visit will result in a certain amount of revenue and the amount of sick leave that will result in additional costs. The managing director explains that the employees at the clinics are not that interested in the financial details of the operations but that they rather focus on concrete numbers like the amount of home visits that is more related to their day to day work.

The divisional manager mentioned that they put a lot of emphasis on finding relevant measures for the operations, but that they were working with some new measures to complement the existing measures. One example of a measure that the divisional manager wanted to implement is the employee turnover, to better get a view of the continuity of the organization. The turnover could also give a better explanation of the performance of the organization, an example given is that the turnover often is a reason for increased costs and could also have a negative effect on the quality. Another factor that was considered regarding the measures that they wanted them to be able to work automatically or electronically to prevent and potential for distortion or human errors in the measures. The divisional manager further remarked that of the ten measurements that were presented only one, the hygiene and dress code, was measured manually whereas the rest was automated.

4.3.3 Setting targets

The targets used at Region Skåne and its primary care clinics all relate to the measures that was mentioned above. Based on these measures the divisional manager receives certain directives from the politicians which later is used to create the same overall target for the clinics. The contract with conditions for accreditation will together with the directives be the deciding factor of the general targets of the division regarding the ten measures included in the balanced scorecard. The targets are then communicated through the management team of the divisional manager down to all managing directors which can comment but cannot affect the overall targets that much. Instead the managing director can create their own targets in areas which they want to focus in addition to the ones presented at the balanced scorecard. They can also set intermediate targets for reaching the overall target over a longer period.

The divisional manager explains that the bar for reaching the targets are high and mentions that approximately 25 percent of all the clinics should reach the targets. Important to consider in regard of this number is that the targets are not adjusted to each but set as an overall target for all clinics. However, since the different clinics have special conditions to reach the targets, all the clinics can set their own targets as mentioned earlier. Thus, if a clinic is far away from achieving a certain target they might use intermediate targets and for example use a three-year plan to reach the overall target of the organisation. Furthermore, the managing director had another approach for setting the targets. Instead they used the budget to estimate the minimum amount for required for a certain target e.g. number of home visits and then used the target as a lowest acceptable level of performance. Further, the divisional manager explains that since the purpose of the clinics is to treat the citizens and work to improve the overall health in the region, many of the clinics lack the ability and the preconditions to manage its objectives and have a financial surplus. One of these factors to the preconditions is explained by the divisional manager as since there is no clear definition of what primary care should include, new tasks can be implemented by the politicians but the financing might be insufficient or not updated to cover these new tasks.

The lack of an overall definition and strategy of the primary care and the changing condition complicates the process of making long term targets. Despite this some long term plans and targets have been set to in their flower model, to set a direction for the organization to strive towards. Since the public primary care is a not-for-profit organization they do not have any pressure to make any short term profit, but as clarified by the divisional manager it is rather a question about using the tax-payers' money efficiently and create as much value as possible.

4.3.4 Evaluation of performance

Each separate clinic is evaluated by the regional managers which are a part of the divisional management team. The clinics are followed up on each of the ten measures presented above monthly. The evaluation is based on a meeting between the regional manager and the managing directors and the supporting economist. The regional manager will then in turn have a meeting with the divisional manager regarding the overall monthly performance of the clinics. However, the balanced scorecard with the overall performance of all of clinics is not

evaluated monthly, which is motivated by the divisional manager with that there are not that many changes over one month so it is unnecessary to update it that often. The clinics are evaluated based on three categories; green if they reach the target, yellow if they almost reached the target and red if they had a low performance. In addition to the green, yellow and red there is an arrow next to each colour explaining the if the trend of the performance is going up or down. The divisional manager is evaluated five times in a year with a larger assessment in the end of the year and the evaluation will cover all the areas in the flower model and the ten measures in the balanced scorecard. However, the divisional manager adds that in the current economic status the financial performance and control of cost takes up most of the focus. This is something that the divisional manager finds unfortunate since the financial target tend to draw attention from the quality and availability measures which is according to the divisional manager more relevant for having a successful primary care.

In addition to the monthly evaluation the managing director uses a weekly meeting with the employees where the balanced scorecard regarding the continuous targets and ideas is evaluated. In addition to this the managing director emphasised to highlight the individuals and have a weekly letter to the employees where special accomplishments and high performance of individuals is acknowledged. However, a potential issue with the evaluations that is pointed out by the divisional manager is that there is always a lag in the measures so that you cannot trust in the measures that is presented. Especially the revenue measures which is given retroactively can differ as much as 10 percent. This will according to the divisional manager complicate the evaluation and in turn maybe affect the usefulness or trustfulness of the results of the financial evaluation. Furthermore, Region Skåne uses the software Qlik to give and overview of how each clinic have performed. These measures are then used to have an internal benchmarking between all the clinics and areas. These benchmarking is later used for transferring knowledge between high and low performing clinics. Based on the performance the low performer will also be offered support in form of recommendations on its processes and education of the employees.

There is no financial incentives or rewards used in Region Skåne, but the divisional manager still mentions the importance of acknowledging and celebrating good performance. The divisional manager further explains that much of the celebration occurs on each clinic where the managing directors have authority to implement these non-financial incentives. Thus, it is quite common for the high performing clinics to celebrate with cake or some other social gathering when achieving intermediate targets or scored high in the internal benchmark. Furthermore, according to the divisional manager there was a change was implemented between 2013/2014 which allowed the individual clinic to bring 85 percent of its "profits" to the next year. During that next year 50 percent of the surplus from the previous period can be used to invest in the business. However, the divisional manager explains that since the current total result is negative, this cannot be used in practice, since this would further increase the cost and the negative result. Thus, in theory the clinics can keep parts of their surplus and use it for reinvestment, but only when the organization as a whole will have a surplus.

4.3.5 Summary

Table 5. Summary Region Skåne

| | | | | | |
|----------------------------------|---|---|--|---|--|
| Strategy and planning | Lacks an overall strategy and vision for primary care | Control tools: - Budget - Flower model - Balanced scorecard | Yearly budget based on conditions for accreditation | High autonomy of the clinics to create their own budget | |
| Measurements | Focus on ten measures included in their balanced scorecard | Measures decided by top management affected by policies from politicians | Managing directors can add additional measures relevant for the clinic | Focus on financial measures at top management level | Higher focus regarding financial measures compared to non-financial |
| Setting targets | Targets are based on the annual budget and the measures in the balanced scorecard | Managing directors are able to set additional and intermediate targets for their clinic | Divisional manager means that targets are achieved by 25% of the clinics | Managing director means that targets are the minimum acceptable performance | The context and inherent uncertainty makes it hard to have long term targets |
| Evaluation of performance | Evaluation of each clinics occurs monthly | Internal benchmarking | Evaluated with a stop sign-principle | Focus on non-financial incentives | No financial rewards |

5 Analysis and discussion

The purpose of this thesis is to generate an understanding of the management control used in Swedish primary care, by analysing the similarities and differences between publicly and privately owned primary care providers. Thus, in this chapter, the empirical material in the previous chapter will be analysed in-between the study objects and with the theoretical framework. Lastly, a discussion of the results will be provided.

5.1 Analysis of empirical results

5.1.1 Strategy and planning

Since there is no general definition of what Swedish primary care should include, the divisional manager at Region Skåne emphasizes the difficulty of setting a strategy and long term plans for their primary care operations. However, both two privately owned primary care companies have clearly communicated strategies that guides the daily operations and decisions, which both circle around three values, and respectively cornerstones. Company A's values seem to be rather abstract and focus on inner beliefs, while Company B's cornerstones are more concrete and practical.

Furthermore, both privately owned companies have a long term focus, and hence make plans and strategies accordingly. Both representatives from Company A explain that they use business plans that lies for 4-5 years' time to guide their work. In Company B, their long term strategy is discussed between top managers and they aim for a long term growth by acquiring other primary care organisations or clinics, which is what Company A has done already. Since all studied organisations need to follow the contract with conditions for accreditation, which determines their revenues for the coming year, they also have a yearly budget process. Their budget's follow the calendar year and all interviewees emphasise the budget's importance for the business. Furthermore, the respondents agree on the difficulty in that contract is set in late November or early December, and needs to be adapted to by the beginning of the following year. However, the three organisations have rather different approaches to that problem. Both Company A and Region Skåne mean that it creates a need to adapt and a lag in the operations, since their budgets is practically set when they get the contract. In Company B, on the other hand, the management tries to understand where the politicians are heading with the contract and use a 15 percent margin while budgeting to have room to adapt once the contract is done and when it is set they use it to finalize their budget.

Besides the yearly budget, the organisations also use other tools to control their employees and operations. However, at Company B the budget is the most important and used management control tool, which is made top-down with managers focusing on the financials, and when handed to the managing directors they use it for practical planning of the operations. At Company A and in Region Skåne, the budget is a part in a larger management control system, where they use a business model respectively a flower model and a balanced scorecard.

In all three organisations, there seems to be a quite clear hierarchy of communication, for who to talk to about what and when. The communication of the control tools and information follows the same hierarchy and levels of employees. A common way of communicating is to have more or less frequent meetings, and the managers meet often with the managing directors. In addition to the managerial meetings the managing director for all the companies seems to have frequent meetings with the employees and the different groups have meetings themselves, and so is the case at Region Skåne.

5.1.2 Measurements

Regarding measurement, it differs between the studied organisations, which probably is a consequence of them having different visions and strategies. Company A aim for high quality and use measures to drive quality, therefore they have both KPIs and QPIs to measure the daily business. Additionally, they measure ACG and have measures regarding employees. Company B, however, derive their measures and KPIs from the contract with conditions for accreditation, since that is the criteria that are demanded from the county council to fulfil. Region Skåne have 10 different measures, whereas nine of them are non-financial ones. Their measures are each connected to one of the areas in their flower model. Furthermore, all interviewed managers have in common that they mean that the measures are set by them and not a demand from higher levels, but they do have directives or guidelines from owners and politicians to follow.

The managers in all three organisations indicated that they have insight in and information about both financial and non-financial measures, and meant that the most important measures are the non-financial ones, which very often regards the quality of the service that they perform. However, the managers in the private organisations concluded that even if they have several non-financial measures and quality matters, it is the financials that truly matters in the end. In Region Skåne, on the other hand, the divisional manager mean that financial measures and money seems to be rather abstract for the ones involved, since financial results have low impact and seldom any consequences. However, since the cost of healthcare and the usage of tax payer money has become a highlighted topic, the divisional manager claimed that the financials tended to get much attention based on external pressure. In the private companies, the managing directors mostly focused on the non-financial measures and did not have just as much knowledge about the causal relationships regarding the economy and financial measures. The managing director in Region Skåne had a more overall perspective, and seemed to be rather knowledgeable about causal relationships between financial and non-financial measures. This knowledge probably comes from the managing director's involvement in the budgeting process.

5.1.3 Setting targets

When analysing the targeting process in the three case companies some similarities could be observed. For all the three organizations, the overall or high prioritized targets seemed to be decided high up in the organizational hierarchy, based from some sort of dialog and instruction from the owners. In addition to these targets, the individual clinics can add their

own targets relatively freely as long as they align or not stands in conflict with the overall targets. The targets seem to have a similar function in all the companies in the sense that they work as a framework for the autonomy of each managing director and the actions at the primary care centre. By implementing and adjusting the targets the top management is available to somewhat control the actions of the managing director without being actively involved and interfere with the autonomy that might be required at a primary care clinic. The main difference between the private companies and the county council organizations is not so much the procedure of the target setting process, but rather the context in where the directives of the targets will originate. The private organizations will receive their directives from their owners, while the county council owners are the local politicians which represent their party. The owners might then have dissimilar incentives of their directives, which in the end could affect the two types of organizations differently. One potential difference is that the owners of the private organization might base their directives on what is best for the organization maybe both to improve short term gains and in quality to assure long term value. Politicians on the other hand might have more complex reasoning behind their directives, since they have to consider the standpoint of their political party and the opinion of the public, to ensure their votes in the next election.

Another observation that was consequent in each of the three case companies was a combination of both financial and non-financial targets. In general, all participants in the organizations seemed to agree that focus in general is on the financial targets, even though their visions and strategies focuses on non-financial factors such as the quality of the given care. Regarding these targets, a trend in the organisations was that the managing directors, which worked closer to the patients than the top management (regional, operational and divisional manager), tend to put more emphasis on the non-financial and quality measures. Whereas top management had a more balanced view of the two types of measure and understanding how they work together. As explained by the regional manager at Company A that "*We measure medical quality to ensure good healthcare to make the business work, and KPIs to improve and work smarter*". This could potentially be a result of the lack of involvement of the medical director in the financial targets, since most of them was implemented by top management. Yet another potential explanation could be that the top management focus more of the performance of the company as a whole, and how they perform towards their customers and owners. Whereas the managing directors will focus more on the performance of their clinic and the treatment of the patients.

During the interviews of the case companies there was some contrasts in the way of how the targets were just in regard to fulfilling them. From the interview with the divisional manager at Region Skåne their targets were just expected to be reached by the top performers, i.e. 25 percent of the clinics. Whereas at Company B both the operational manager and the managing director answered that the targets were created in a way that they should be accomplished for each of the clinics. Company A in turn used different types of targets, both more visionary targets which was used as something to strive towards and more practical

targets which should be reached for each year. According to the managing director at Company A they had strict financial measures for each year. Thus, in this regard, all companies have their own approach of how to decide the success rate and how to approach the targets. However, one reason for the private companies to be relatively stricter regarding the accomplishment of the targets could be that they are more financially vulnerable than the public organization. It is therefore more important for the private organizations to reach their targets both financial and non-financial since "*its quality that drives the economy*", as stated by the regional manager Company A to survive, plan for the future and have a good relationship with the owners and investors.

Regarding the time period of the targets, all of the organizations seem to base their targets on a yearly basis. The targets will be based around the budget and will therefore as mentioned be highly affected by the yearly contract with conditions for accreditation agreement which will decide the income for the year. Since the contract will change from year to year, it seems to be rather hard to have any concrete long term targets. Instead many of their long term targets will be more inspirational and connected to the vision of the organization for example, creating the best possible care. However, the overall impression received while interviewing the managers in each of the organizations is that they all seem to work with a balanced focus of long and short term either by using a business plan, a flower model or by having a continuous dialog with the owners.

5.1.4 Evaluation of performance

The evaluation process of both the private primary care providers and the one managed by Region Skåne focus on the monthly follow-up of the budget in regard to the monthly closing of the books. The evaluation of the individual clinics and the organization as a whole tend to focus around the financial performance. However, many of the managers, both at the clinics and at the top management level, seem to believe that the non-financial measures are more relevant for improving the quality and operations of the companies. Furthermore, Company B uses weekly update of the performance of their clinics in order to be more agile to be able to identify and adapt to trends in the performance. This is not something that is mentioned at Company A or Region Skåne, even though these organizations also had a dialog between top management and the clinics in between the monthly evaluations. One potential explanation for this could be the fact that Company B is a smaller organization than both Company A and Region Skåne which could make it easier and require less resources for them to have a continuous update of all their clinics.

Similar in all the case companies was that the evaluation at the top management level seems to focus on the performance of each of the clinics and the managing director whom is responsible for its performance. The evaluation of the operative employees such as nurses and doctors seems to be made by the managing directors and their management team, either by having monthly meetings with the staff or by as in the case of Company A and Region Skåne to have a weekly letter and updating the employees. Much of the individual

evaluations seems to be managed by the employees themselves by using peer-reviews e.g. the nurses and doctors will manage the individual performance by themselves.

Yet, another important tool for evaluation and tracking the performance is benchmarking, which was mentioned in all the three case companies. For both Company A and Region Skåne, they seemed to focus on internal benchmarking between the clinics and regions, but also to see trends in time from different time periods. Company B takes the benchmarking one step further by collaborating with external actors operating within primary care as well. As explained by the operational manager at Company B, by building trust with the other private actors within the primary care and sharing knowledge, all parties gain on this collaboration. A potential reason for Company B to do this, or for Company A and Region Skåne to avoid the external benchmarking, could once again be a result of the size of the organisations. Company B is compared to the other two relatively small and might require external collaboration to reach the same sample sizes and experience that the two larger organizations already might have internally. It could also be a result of the fact that Company B as mentioned by the operational manager emphasises an agile and dynamic primary care that might depend upon a more external view and understanding of the market.

Regarding the use of incentives and rewards in the primary care, all the participating organisations seemed to emphasise the non-financial incentives of the organisation. As explained by the managing director at Company B whom mentioned that the employees at the clinics had high internal motivation and work ethics to do a good job for the patients, which will reduce the need for financial incentives. Instead the incentives at the clinics consisted of feedback and praise of high performance, as well as some smaller celebrations together. Regarding the financial incentives, the replies differed between the companies but the answer could also differ within the companies themselves, which could a result of this being a rather sensitive topic. In Company A, the regional manager mentioned that they had used financial incentives but it had not been done lately as a result of a harsher financial situation for the organization. The managing director on the other hand replied that financial incentives was used if they exceeded the financial targets in the budget. The easiest potential solution for this could be that a financial incentive is used for the managing director, whereas they are not used for the regional manager, but since we lack information for a proper solution it feels unnecessary to speculate in that area. In Company B and Region Skåne no financial incentives were mentioned being used, even though the operational manager at Company B decided to not answer the question, similar to the case at Company A speculation feels unnecessary. A more relevant difference between the three Companies was that only Region Skåne had a system where the individual clinic was allowed to keep some of its financial revenue to use for investments the next year. Even though this is not currently being used since the overall result of the primary care in Region Skåne has been negative, it has previously been used and is a possibility. Whereas for both the privately owned organizations the clinics will start fresh in the beginning of each year. As mentioned by all the managing directors this could have a negative effect on the motivation to exceed the budget and adapt

the financial measures. This could potentially be an additional reason for a low involvement or interest in the financial measures by the operative employees, since there is no clear gain for the clinic or patient to fulfil the financial targets.

5.2 Findings in relation to theory

5.2.1 Strategy and planning

Previous literature by Franco-Santos, Lucianetti and Bourne (2012) emphasises the importance of an underlying and the alignment of the performance measurement system towards the strategy to be relevant for the organization. As explained by the divisional manager at Region Skåne, there is no general definition of the primary care and no national plan nor strategy. This could potentially be a huge disadvantage for the public organization since there is no foundation in which to structure the operations and management system. Even though there is a lack of definition for the private providers as well, they could naturally adapt and avoid this problem by being a for-profit organization. Regardless if the foundation is based on profitability or quality, there will be a natural strive for survival which require a strategy and a vision. Having an overall strategy could in addition to a stable base, also improve the private providers' ability to make long term plans and continuity in both the operations and the performance measurement system. Something that the divisional manager at Region Skåne admitted was hard, since the directives and management highly depended on the politicians currently in charge.

In accordance to previous theory by Malmi and Brown (2008), the main tool for *planning* in all the participating companies was the budget and the budgeting process. Since the budgets are depending on the contract with conditions for accreditation from the county council which is not received by the companies until December, this seemed to primarily have two effects. The first one is that the late contract with the conditions gravely affected the companies' ability to plan for and adapt to the conditions for the next year. The potential second consequence is that the budgeting process would be unnecessary expensive and demand a lot of resources of the companies as well as reduce the reliability of the budget. Since the budget process done before the contract is done will be based on estimates and most be reworked afterwards to fit the new conditions. Company B which tried to be more agile and plan with a margin before receiving the conditions might be able to reduce the amount of resources and strain on the management related to the budgeting process.

Malmi and Brown (2008) further discuss that the *planning* process used consists of actions planning and long range planning. The budget seemed to work as the framework for the action plan in all of the participating companies and focus with a tactical function of how to manage the clinics in regard to the yearly contract with the county council and how to allocate its resources. Only Company A mentioned a formal tool for the long term planning in their use of a 4-5 year business plan created by the managing director at each clinic. The flower model used by Region Skåne had a combination of long and short range planning and

evaluation and was created by the divisional manager to despite the lack of a long term plan and strategy from the politicians to give an overall direction for the clinics in that division. Company B did not mention any formal tools for long term planning, they instead used an informal tool by having a continuous dialog with the owners and discuss the direction of the organization and implementing its strategy. This aligns with the statement of Malmi and Brown (2008) that the planning is not just based on formal controls and financials measures, but that there are multiple ways of planning and that the financials rather is a way to concretize the plan and strategy of the organization.

5.2.2 Measurements

Malmi and Brown (2008) argued that there were three types of measures in the management control system the financial, non-financial and hybrid measures. As presented in the empirical chapter, there seems to be a classification of financial and non-financial measures in all the case companies but also some traces of hybrid measures in for example the balanced scorecard and the flower model used by Region Skåne. Ferreira and Otley (2009) further explains that the measures should be used to evaluate the companies' ability to achieve its vision and should therefore derive from the organizations' strategy. As observed in this study, there seems to be two main factors which affects the measures used by the case companies. The first factor is the strategy of the companies which aligns with previous theory. The second factor is external and based on the contract with conditions for accreditation, since the contract will decide the revenue of the companies they tend to measure what is currently emphasised by the county council.

In accordance with the study by Kraus and Lind (2010) the top managers of each of the organizations tend to focus more on the financial measures, or at least have a balanced view of the different measures. However, contrary to result by Kraus and Lind (2010) the top managers of these organizations seemed to trust in the non-financial measures and saw them as more relevant for the organization. Signs of this was seen both in Company A where the regional manager emphasised the importance of the non-financial measures and at Region Skåne where the divisional manager stated that it was unfortunate that the financial measures took too much focus, since the non-financial ones were the most relevant for understanding the organization. Thus, there is not a lack of trust that shifts the focus towards the financial measures. The reason for the financial focus probably includes many factors. External factors affected by the context of the healthcare sector such as survival of the business, stakeholders interest or efficient usage of the taxpayer's money. Or more practical factors, such as the financial measures being relatively concrete and easy to use in evaluations and control for top management.

Some participants in the interview mentioned the problem with measuring within the primary care, since they work with people and many measures such as satisfaction is based on feelings of the patient. As described by managing director for Company B, a high satisfaction rate does not automatically mean a high quality and a customer that have received the best possible care could still be unsatisfied. This discussion, together with the preference of non-

financial measures mentioned earlier, seems to have similarities with the reasoning by Ittner and Larcker (2003) and Hopper, Northcott and Scapens (2007), about non-financial measures, where they state that the non-financial ones might show a truer picture of the company's operations, but that at the same time is harder to measure objectively.

5.2.3 Setting targets

As seen in the chapter above there are both similarities and differences in the way that the companies use targets. All organizations use both financial and non-financial measures to trace to overall performance in the organization which otherwise have according to the interviews in the empirical study have a high degree of autonomy. As seen in all the participating companies, the usage of targets for top management seems to be as a way to affect and focus the behaviour of the managing director towards certain areas. By setting certain targets the management could align the individual goals and actions with the overall vision of the company. This is similar to what is described in our theoretical framework as mentioned by Malmi and Brown (2008) that the *cybernetic controls* should be used to link behaviour to a certain target. This usage of the targets could also be described as what Simons (1994) refers to as *boundary systems*, to be used as a framework for the freedom of the managing director and the employees. The top management could with the help of the targets and the choice of measurements steer or focus of the decisions of the management towards certain areas without giving direct instructions and interfere with the perceived autonomy of the individual clinic.

All participants in the study mentioned some sort of benchmarking in regard to evaluations and targets, which agrees with the statement by Ferreira and Otley (2009) that benchmarking is often utilized in the healthcare sector. Furthermore, Spendolini (1992 in Ferreira & Otley, 2009) describes the technique as a way to legitimize the used targets. They further argue that especially external benchmarking increased the legitimacy which was something that Company B emphasised, whereas Company A and Region Skåne mostly seemed to focus on internal benchmarking. However, important to remember is that Company B is considerably smaller than the other participating companies, which will give them a smaller sample for internal benchmarking.

Regarding the achievability of the targets, Franco-Santos, Lucianetti and Bourne (2012) and Ferreira and Otley (2009) explains a tension between the desired and feasibility of the targets. They further explain that relatively hard targets with a success rate of 80-90 percent had a positive effect on performance. Compared to the participating companies in the study, the private providers of healthcare seemed to strive toward a 100 percent achievement rate but still had rather strict targets that was not always obtained as explained by the managing director of Company A. Thus, there is a possibility that the targets in the private organizations will be around the 80-90 percent achieved. The divisional manager at Region Skåne on the other hand described that approximately 25 percent of the highest performing clinics achieved the overall targets set at the divisional level. Since only a few clinics are able to achieve the target this might reduce the effectiveness to use the targets as a management

tool to control the behaviour and actions of the employees at the clinics. This in combination with the minimal impact of a negative economic result as explained by the divisional manager at Region Skåne, could potentially explain parts of the issues in managing the public organization as a for-profit organization with focus on the financials performance.

5.2.4 Evaluation of performance

The participating organizations had a rather similar process of evaluation where the formal evaluation primarily occurred monthly, based on meetings either manager to manager or manager to other employees. In addition to the monthly meetings some more informal weekly staff meetings are used for planning and evaluation. Ferreira and Otley (2009) argues that the routines for evaluation not necessary is the evaluation and that factors such as trust and the perception of the situation is important factors in the evaluation. Based on the answers received by the participation managing director the evaluation seemed to work more as a dialog of between the managing director and its manager to inform about the month and explain certain abnormalities from the budget. In addition of the evaluation process to work as a way for the management to get an insight in the operations of and the performance of the managing director, it also seems to work to build trust and autonomy. As explained by the managing director at Region Skåne, if they perform in accordance with the budget the management will spend less time in analysing their operations in detail and give the managing director more freedom in managing their own clinic. On the opposite side the manager could use the evaluation both to keep track of the performance and understand the operations of the clinics, and focus their efforts on low performing clinics that require more support or involvement. Thus, the evaluation process could be regarded as what Simons (1994) describes as *diagnostic control systems* where managers can keep track on critical performance variables, and also as *interactive control systems* where the managers can highlight certain areas in the business and get more involved into the operations. The interactive control systems can also somewhat be seen at the clinics where the managing director can emphasize on certain measures, one example given is that the managing director at Region Skåne had a weekly follow-up regarding the amount of home visits which increased the importance and focus of that measure at the clinic. Furthermore, most of the evaluation for the top management and managing director will be the clinics performance as a whole with some elements of group and individual level in staff meetings and the individual yearly salary negotiations. However, the managing director at Region Skåne mentioned the importance to see the individuals and used a weekly newsletter to highlight certain individual performance.

As seen in the empirical chapter, the general opinion regarding the incentives used in the primary care was based around non-financial measures such as acknowledgement, feedback and small social celebrations. Even if some individual financial rewards were used for management at Company A they did not seem to have that high roll of importance for motivating the employees. This could be explained by Ryan and Deci (2000) that tasks that by its nature have a high complexity and involvement as the case is in the healthcare. The

employees tend to have a high intrinsic motivation where the value of performing the task itself is the incentive and no extra external incentives are needed. This could be seen in the statement from the managing director at Company B which mention that there is no need for any financial incentives, since the employees have a high moral and is motivated by doing their job as good as possible by threating the patients.

Another interesting fact regarding incentives and motivation at the individual clinics, is that only the public primary care by Region Skåne had some sort of system where the individual clinic had incentives to exceed budget by keeping some of the profit. At both the private companies the clinics finances would start over from zero for each year and they were not able to keep any of their profits or losses for the next year. Both the managing directors at the private companies mentioned that this could have a potential negative effect on the employees' motivation to exceed the targets in budget, since it didn't give them any advantages or ways to improve the treatment of patients.

Finally, the problem with incentives and rewards described by Kerr (1995) and Kraus and Lind (2010) regarding rewarding the right behaviour and aligning the rewards with the strategy of the organization, can somewhat be seen in the participating companies. All the participating managing directors and some of the top managers mentioned that the focus on the evaluation of the clinics tended to be on the financial measures rather than the qualitative measures. However, a common nominator for all the companies seemed also to be that the closer to the patients the less focus was used on the financial measures. Thus, just because the focus by top management seemed to be on the financial measures does not necessarily only have to be a problem and a distortion from the overall vision of high quality healthcare of the companies. Instead, it could be that top management must assure the survival of the organization financially and by doing so enable the employees that work closer to the patient to, with high autonomy, find the best way to treat the patients, which then in turn could improve the economy of the organisation.

5.3 Discussion of results

One of the main findings when comparing the public and private primary care providers is that even though there are differences in the ways of using management control and performance measurement, the reason behind it are often completely dependent on external factors. Thus, the context of acting within the public sector is identical for all the of the studied organisations. All respondents highlight the specific regulations regarding primary care and the contract with conditions for accreditation by the county council, as major influences on the operations and their ability to manage and control the organisation. Thus, the context is rather controlling in all studied cases and the contract acts as governance in form of an *administrative control* (Malmi & Brown, 2008) that sets boundaries for their operations (Simons, 1994). Hence, there is parts of the management control used which they have no ability to influence. The contract with conditions for accreditation directs the primary

care providers' planning, and thus the rest of their management control process. On the other hand, the organisations also need to adapt to requirements and the informal codes associated with highly professional employees consisting of doctors and nurses with their own agenda and motivation which not always align with the strategy of the organization. Thus, the values and clans in the organisations is also rather controlling, and act as *cultural controls* (Malmi & Brown, 2008). Additionally, the ownership might give all the companies different initial underlying factors which could affect their management. For example, the public organizations strategy and vision might depend completely on a certain political party's opinions regarding primary care, which could be completely different compared to the vision in a privately owned company, which is set by the owners.

In regard to the theory of Ahrens and Chapman (2004) which discuss *enabling* and *coercive control*, both the private and public primary care providers seems at a first look to focus on enabling control and high autonomy and little top management involvement in the daily operations and decisions. However, this completely depends on the view of looking at the operations, compared to a traditional factory floor with repetitive tasks and micromanagement it gets rather easy to say that the performance measurement system and its control tools are very enabling. This comparison might not be applicable while evaluating a high professional organisation though. If instead the individual doctor acts as a starting point, the doctor probably prefer absolute autonomy and to only focus on treating the patients regardless of financial and non-financial measures and set targets that is impossible to adapt to the individual patient. Thus, in that sense the primary care providers' management control could also be seen as a way to coercively control the employees, limiting their autonomy. This phenomenon can also be related to *boundary systems* mentioned by Simons (1994) where the management control process is used to limit the freedom of the employees, without directly limit their freedom. Company B had a rather unique approach regarding their operations where much of the administrative tasks had been moved to the top management level, which works as a support for the clinics. This solution could be seen as the operational manager described, a way to remove the administrative burden from the clinics, but it could also be seen as a way to centralize the power to the top management. However, based on the information given by the managing director, its seems to work as a way to free up time and resources for the individual clinic to focus on treating the patients, which in that case seems very relatable to the enabling control.

6 Conclusion

This chapter contains the conclusion of the thesis, and starts with presenting the main findings of the study, derived from the empirical material and the framework for analysis. Further, the main contributions and limitations will follow, and the chapter end with suggestions for future research being mentioned.

6.1 Findings

This purpose of this thesis was to generate an understanding of the management control used in Swedish primary care, by analysing the similarities and differences between publicly and privately owned primary care providers. The main result of this study is that even though there are some general differences in the management control used by the participating primary care providers, there is no consistent public or private way of using management control. Instead there seems to be as many differences and similarities between the two private organizations as there is compared to the publicly owned one.

The overall foundation of the management control used by the providers is rather identical and seems to be decided, or at least affected, by the context. This context is represented as the *administrative* and *cultural controls* in the analysis model, in which the organizations operate and adapts to several factors, rather than being control themselves. Some of these factors regards the *administrative controls*, which includes the legislation and governance structure of the organizations. One clear example of this is that much of the planning will be done yearly and centralized around the budget process that in turn is highly affected by the contract with conditions for accreditation, which is decided by the politicians at the county council. The contract will then decide the payment to the providers of healthcare services, which then naturally will affect the measures and targets of the organizations, for example the number of home visits. Furthermore, another contextual factor that creates a similar base in the management control used is the *cultural control*. Consistently in all the organizations is that the clinics and managing directors have a high autonomy in regard to the practical decisions of the operations and the actual service to the patients. It has been shown throughout this thesis that the closer you get to the operations and the patients the more the focus and involvement will shift away from the financial and administrative objectives towards quality and treating the individual patients. Whereas many of the overall administrative decisions are made by top management and communicated downwards in the organization through the managing director.

Having mentioned the similarities based on the context in which the companies operate, the differences relates more to the companies' strategies to adapt to these factors and how the companies will use the different management control tools to align the behaviour in the organization with the strategy and vision. One example of this is the strategy used by Company B where much of the administrative tasks had been centralized, taken away from the individual clinics in order for the clinics to focus on the treatment of patient and for the top management to be able to make faster decisions. In addition to this, Company B uses a

weekly evaluation process to better identify trends and be more agile to the market, which further aligns with their strategy. A general difference between the private and public primary care, which has been brought up by the respondents that had experience from both public and private is that the private organizations seems to be more agile and flexible with abilities to take faster decisions than the public providers. Flexibility and faster decision-making has also been emphasised by both the private organizations. If the higher flexibility and faster decision-making is a result of the internal management of the private organizations or the context in which they operate is hard to tell. The most plausible explanation is that the increased flexibility is a combination of both factors, where the bureaucratic and political environment of the public organizations is something that the private providers wants to avoid and take advantage of, by emphasising their faster decision making.

6.2 Contributions and limitations

The implications of thesis will hopefully contribute to a deeper understanding regarding management control in Swedish primary care and how it might differ depending on the ownership structure of the primary care providers. The thesis will, with the help of its qualitative approach, give some practical insight in how performance measurement and management control actually is used by Swedish primary care providers. Furthermore, the qualitative approach of this thesis could be used to complement existing research, which mostly consists of quantitative studies, with a deeper understanding and operative insight in the organizations.

Using a case study approach limits the study to the extent that the results should not be used to generalize the entire population, and the small sample size of providers will further affect the findings, where each case company have a high impact of the study's result. However, the purpose of this thesis does not include the ability to generalize its result, but rather to explore and compare the participating primary care providers. Therefore, the findings could instead potentially inspire future research in area of management in the primary care.

Furthermore, the model used for analysing the empirical data might come with inherent limitations and might not provide a complete view of all the factors regarding the management control in an organization. By combining previous theory by Ferreira and Otley with Malmi and Brown we have made efforts to strengthen the relevance and reliability of the model. Nevertheless, it is possible for potential limitations in the previous theory to be transferred and thereby exist in this research as well.

6.3 Future Research

Since the findings in this thesis is not generalizable, we believe that the results could be used as indicators of the management control in the public sector and can inspire future more extensive research. The method used in this thesis can originate hypotheses whose general

validity can be tested and falsified or strengthened for a large number of cases with the use of quantitative method. Thus, it could for example be interesting to have a more longitudinal case study based on observations of the operations rather than interviews. This study has also focused on the managers' usage of the management control, which could be interesting to complement with including even more employees on lower levels at the primary care clinics.

Furthermore, we believe the role of the framework in this study is to provide a snapshot of the management control that are in operation at one particular point in time. As such, we believe that it can serve as a useful research tool to enable such practices to be documented and correlated with other variables, in future studies done over time.

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Appendix

Interview guide

Planning

What strategies and plans has the organization adopted, and what are the processes for these? How are strategies and plans communicated to managers and employees? How do you work for achieving the strategies and plans, and make sure that they are followed?

Measurement

Deriving from your strategies and plans, what are the organization's key performance measures? How is the relationship between what you must measure and what you want to measure? How are these measures communicated throughout the organisation? Are there any gaps in what is being measured, anything that is not measured that should be?

Targets

Linked to the key performance measures, what level of performance does the organization need to achieve for each of these? How do you set appropriate performance targets for the measures? How challenging are those performance targets?

Evaluation

What processes does the organization follow for evaluation and follow-up of performance? What role does the previously discussed measures and targets play in the evaluation? How do you connect the evaluation to the future planning of the business? How do you evaluate organizational, group and individual performance? Are performance evaluations primarily objective or subjective?

If a primary care centre achieves its financial objectives, do they get to keep their surplus/cover losses, or is this transferred to the parent company/group?

What rewards (financial and/or non-financial) will managers and other employees gain by achieving performance targets? Or, what penalties will they suffer by failing to achieve them?