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Innovation and management control in Swedish primary care

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Abstract

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Five key words: Primary care, management control, innovation, enabling and coercive control, Simons´ levers of control.

Purpose: To study the tender documents used by the regions to control the primary care providers in Sweden. In doing so, a greater understanding about the tender documents from a management control perspective will be obtained, and their effects on innovation.

Methodology: The Swedish regions' tender documents are analyzed using thematic analysis in order to identify themes relating to management controls used by the regions towards primary care providers. 10 out of the 21 regions are studied for the years 2013 and 2023.

Theoretical perspectives: The study uses a management control perspective when analyzing regions' tender documents. Furthermore, the concepts of enabling and coercive control are used, paired with Simons´ levers of control framework.

Empirical foundation: Tender documents, from the ten regions for the years 2013 and 2023, which serve to state the terms for running a health center and provide guidance for primary care providers active in the regions.

Conclusions: The findings show that the tender documents favor coercive control compared to enabling control, this holds true both for the year 2013 and 2023. The heavy use of coercive control in tender documents has a negative effect on explorative innovation, but is possibly beneficial for exploitative innovation.

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1. Introduction

The introduction introduces the reader to the privatization reform of Swedish primary care and its effects. Furthermore, the situation regarding Swedish healthcare in general is problematized. Lastly, the paper's purpose and research questions are introduced.

1.1 Background

Swedish healthcare is the responsibility of the regions, which were previously called county councils. The regions are part of the Swedish government, aside from the municipalities and the national-government. They are largely independent from each other and the national-government due to the principle of municipal self-government. One part of healthcare, which they are responsible for, is primary care. Whether the responsibilities fall on primary care, or on other parts of healthcare, is both regulated in law (5 § Hälso och sjukvårdslagen), but mostly up to the regions to define due to the principle of municipal self-governance (Socialstyrelsen, 2016). The law states that the primary care should deliver basic medical treatment, care, proactive treatment, and rehabilitation that does not require the hospital's more advanced medical and technical resources (Socialstyrelsen, 2016). Apart from this law, the regions differ on which tasks, demands and what terms it gives to primary care or other parts of healthcare (Socialstyrelsen, 2016). For example, primary care providers in all regions are given the responsibility of providing on-call healthcare and assisting in disease controls, but not all have to provide vaccination and do medical check-ups on asylum-seekers (Socialstyrelsen, 2016). This means that there is a varying degree of difference in managing a primary care depending on which region you operate in.

There has been a weak development in Swedish primary care historically and in the early 2000s it was evident that there existed a gap between the services pledged to be delivered and the available financial and physical resources (Glenngård, 2016). The primary care also experienced low trust from the citizens (Glenngård, 2016). Introducing competition and freedom of choice was seen as a solution as it would increase efficiency, quality and have a higher responsiveness to the citizen’s needs (Glenngård, 2016). It should be noted that competition was already present but managed under “lagen om offentlig upphandling” (SKR, 2010). The choice-reform was made a reality with the law “lagen om valfrihetsystem” (LOV), roughly translated to “the law regarding freedom of choice”. It states that citizens can choose from different actors when it comes to services that the region is responsible for. One

of these is primary care where private actors can provide primary care if they meet the requirements set by the regions (SKR, 2010). The legislation was introduced in 2009 with the motive of providing the citizens with a choice in choosing their primary care provider, and therefore receiving more power (SKR, 2010). Another reason was that it was expected that the competition would lead to greater efficiency and cost-savings, in addition to the ideological motives with privatization (SKR, 2010). In 2010 it became mandatory for the regions to offer private actors the opportunity to provide primary care (SKR, 2010). The private actors are mostly funded by public funds (SKR, 2010). As the regions set the terms, and publish new ones each year, running a primary care differs from region to region and year to year (SKR, 2010).

Instead of creating a free market the reform created something better described as a quasi-market (Glenngård, 2016). Monopolistic public providers were replaced by competitive providers, but the providers cannot compete in terms of price because consumers' purchasing power is expressed in terms of earmarked budgets instead of in monetary terms (Glenngård, 2016). Competition is instead expressed through the quality and types of services provided (Glenngård, 2016). The separation of payment and delivery of services result in the accountability being shared by both government and the private providers (Glenngård, 2016). In addition, governments are still responsible for the achievement of the overall objectives of primary care, in their role as policy makers and payer of services it therefore becomes important to set requirements, allocate resources etc. (Glenngård, 2016). Hence, providers' responsibility stretches to both citizens and the government (Glenngård, 2016). Socialstyrelsen (2019) describes how Swedish healthcare is generally enthusiastic about innovation but there are several issues concerning their work with it. There is a lack of funding, poor cooperation between different actors, strict problem-formulation, and a lack of continuity (Socialstyrelsen, 2019). They also conclude that the forces driving innovation are weaker in primary care, compared to those at hospitals.

One of the ways in which the regions exercise management control over the primary care providers is through tender documents. They are unique for every region and are updated yearly. The documents contain a variety of information regarding what capacities the providers must have and also what goals and values should guide them. They are also called different things such as “quality and demands book”, “rulebook” and “manual for

healthchoice". Glenngård (2016) conveyed that these documents possibly limit providers' ability to meet citizens' and government actual expectations.

Glenngård (2019) examines the governance model used by regions to control primary care providers. The study finds that the intended role of governance is to both force compliance by being coercive, but also to support learning and quality improvement. She continues to discuss the appropriate governance model from governments point of view and concludes that it should include high levels of controls emphasizing compliance but also learning and quality support, with a little more emphasis on the latter two. This governance model is preferable to ensure providers deliver high quality services but still provide them with appropriate support (Glenngård, 2019).

Glenngård's (2019) findings suggest that the management controls used by region to control primary care providers are aimed at both compliance but also to quality improvements and learning. Arvidsson et al. (2021) and Glenngård and Anell (2021) findings suggest that at least part of the management controls used are perceived to be much more focused on compliance rather than quality improvements. Arvidsson et al. (2021) examined how health center managers and professionals experience feedback and audit practices in Swedish primary care, and how these create conditions or barriers for quality improvement work. Arvidsson et al. (2021) found that the main aim of regional managers' audit and feedback was to control compliance to contractual obligations, thereby focusing on external accountability. The external focus and use on non-clinical measures were perceived as a barrier to quality improvements by professionals. Interviewees also experienced a discrepancy between targets used and quality improvement (Arvidsson et al., 2021). Arvidsson et al. (2021) findings reveal how the audit and feedback conducted by regions might act as barriers concerning innovations related to improving quality. On a similar note, Glenngård and Anell (2021) found that the audit and feedback from the regions was perceived as being top-down, focusing on adherence to contractual obligations, financial obligations and clinical guidelines. In the five regions studied, feedback was given to the provider from the region once a year or even less frequently (Glenngård & Anell, 2021).

1.2 Problematization

Managing resources as efficiently as possible and providing equal care is not always the same as having a management control system that promotes innovation (Skoog, 2018). This creates a conflict in all healthcare, including primary care. New methods and innovation infer a departure from best practice and can therefore be difficult to encourage if the goal is to deliver the best care according to current evidence (Skoog, 2018), someone has to take the first step. He also states that there is a goal-conflict between providing care for those with the greatest need, and doing what is best for the health of the population.

Primary care is also facing a demographic challenge. Sweden's population is getting older, during the last 50 years the number of people over the age of 60 increased by 65 % to more than 2,6 million (SCB, 2022). People over 90 years of age have more than doubled during the same period (SCB, 2022). Meanwhile the population growth as a whole is under 30 % (SCB, 2022). As people get older, their medical needs increase. In combination with fewer young people who can work in healthcare, Sweden is facing a big challenge in caring for its aging population with limited resources both in the form of money and personnel.

Both the covid-19 pandemic and the escalation in the ongoing war in Ukraine has also made people, once again, aware that it is not enough for healthcare to function in times of peace and normality. It also needs to be able to handle catastrophes in different forms. The war in Ukraine, which has gone on from 2014 (Walker, 2023) also points to the fact that it must be able to do so for a prolonged period of time. This means that it needs to be able to both care for those affected by the catastrophe, but also the ordinary need for healthcare, such as primary care. Furthermore, as most funds come from the public (SCB, 2022), they have a responsibility to manage these resources effectively.

To deal with the aforementioned issues, primary care must be innovative. Innovation is necessary to all organizations to not stagnate. It can help cut costs, improve quality, increase efficiency and to explore new opportunities. Furthermore, as Socialstyrelsen (2016) states, one of the main points of the choice reform was that giving power to the consumers away from politicians and government officials would lead to increased diversity which in turn should increase quality and efficiency. In other words, innovation was one of the key goals of the reform. If this has not been achieved the reform has not achieved its desired purpose.

Previous studies have shown how the “LOV” reform has not entirely had the desired effects (Glenngård, 2016), one of these effects is the increase in innovation (Glenngård, 2019; Socialstyrelsen, 2016).

However, innovation is an ambiguous phenomenon with multiple dynamic and complex factors affecting it. This paper argues that regions can use management control to affect providers' innovativeness. Malmi and Brown (2008) express the importance of viewing management controls as a package, where the links between each management control system is considered instead of viewed in isolation. In this context, tender documents will be considered a part of the wider management control package used by regions to control providers.

1.3 Purpose

This paper will study the tender documents used by the regions to control the primary care providers in Sweden. In doing so, a greater understanding about the tender documents from a management control perspective will be obtained, and their effects on innovation. This will be accomplished by answering the research questions:

1. What types of management controls do the tender documents favor?
2. Have the management controls in the tender documents changed between the years 2013 and 2023?
3. How do the tender documents affect the innovativeness of primary care providers?

Fulfilling this purpose will have several practical and theoretical implications. The practical are that it will provide insights regarding the tender documents for the primary care providers, regions and professionals. The insights from the paper could be used to develop, or at least understand the effects of what is written in the documents. It will also provide more knowledge regarding the choice-reform, which is valuable for politicians, and the voters when choosing said politicians. The main theoretical implication of the paper is to show if it is possible to use management control theory when analyzing the tender documents, or other similar documents. It will also provide a base for further research in this field.

2. Theory

This section explains why a management control perspective has been chosen to study the phenomenon, followed by a section which conceptualizes innovation. Thereafter, the concepts of enabling and coercive control presented together with Simons´ levers of control framework. Lastly, the relationship between management control and innovation is discussed.

2.1 Why management control?

The relationship between the region and providers is arguably first and foremost a contractual relationship. Providers perform a predefined assignment on the command of the region where the requirements stipulated in the tender documents creates its guidelines and boundaries. The principal-agent theory can be useful when analyzing such a relationship. The theory is applicable in situations where a principal, in this case the region, gives an agent (the provider) authority to perform certain tasks (Jensen & Meckling, 1976). Both parties are considered utility maximizers and self-serving. However, the provider has more information relating to its actions. The region must therefore control and monitor the providers to ensure that they act in the region's best interests (Jensen & Meckling, 1976). Control and monitoring activities are costly and the region must therefore balance the agency costs versus the benefit (Jensen & Meckling, 1976).

However, the principal-agent theory is not optimally suited to analyzing how the requirements affect the ability and incentives to innovate. For one thing, there are multiple particularities of the relationship between the region and the provider and the service provided. In most cases it is a long-term relationship where the region is working together with providers to create a well performing primary care system for the citizens. In some areas the relationship therefore moves beyond the boundaries where the region is simply controlling that tasks are performed by the agent, but instead forms of management control becomes more important. Innovation is one such area, it is an ambiguous phenomenon which can’t simply be managed by the contractual obligation to be innovative complemented by subsequent monitoring. Instead, there are multiple dynamic and complex factors, such as culture, which contribute to determining the conditions that affect innovativeness. Adding to this, Skoog (2018) describes a goal conflict between providing the best care possible and innovation, where innovation infer a departure from best practice. Such goal ambiguity cannot be easily managed simply through a contract. It requires more active management to

balance the pursuit of these somewhat opposing goals. A management control perspective is therefore more suitable when analyzing the phenomenon and to answer the research question. It will allow analyzing the controls used more deeply and their effect on innovativeness by going beyond the perspective of agency theory. It will also be more useful in settings where the achievement of objectives can be somewhat conflicting, such as ensuring that citizens are receiving adequate care from the providers, and to facilitate innovation in primary care organizations. Such situations require active management control to move towards the desired direction.

Simons (1995) uses the following definition of management control systems: "*the formal, information-based routines and procedures used by managers to maintain or alter patterns in organizational activities*" (p.170), as does others who utilize his framework, Barros and Ferreira (2022), and Bedford (2015). However, we argue that it is also applicable when analyzing the relationship between regions and primary care providers. This is because the region has the responsibility in relationship to the citizens to ensure that the primary care system performs well and also evolves to tackle future challenges. Innovation is essential to evolve and develop, and the use of management control can either stifle or stimulate innovation. The region is therefore utilizing information-based routines and procedures to maintain or alter the organizational activities of providers, which is reflected in the accreditation requirements. This viewpoint is shared by Glenngård (2019) who expresses that controls used by governments to hold providers accountable can be described as a management control package. The next section will conceptualize what innovation is and explain its multifaceted meaning.

2.2 Enabling and Coercive control

Glenngård (2019) studies governance models in Swedish primary care from the region's point of view using Adler & Borys (1996) distinction between enabling and coercive use of management control systems. It is expressed as a way to describe management controls in a more general way (Glenngård, 2019). The use of these concepts therefore serves to give general descriptions of the use of management controls in regions' tender documents which are easily comparable to other studies. It will also allow an easier and more clear comparison of the management controls in tender documents between the different regions. In addition, many studies have relied on the framework of enabling and coercive controls (Bisbe, 2019),

demonstrating its validity. The enabling use of management control allows employees to better perform and master their tasks (Adler & Borys, 1996), enabling them to directly deal with the contingencies in their work (Ahrens & Chapman, 2004). Coercive use on the other hand, coerces employee´s effort and aims at compliance (Adler & Borys, 1996), utilizing the stereotypical top-down approach which emphasizes centralization and preplanning (Ahrens & Chapman, 2004). In the context of the study, the focus will be on to what degree the tender documents are enabling providers to master the services they provide within the primary care space, or if the tender document instead encourages compliance and coerce provider's efforts.

To make a detailed description and analysis of the use of management control, the study will adopt the framework Simons´ levers of control. Simons (1994) conceptualized management control systems into four types: belief systems, interactive control systems, boundary systems and diagnostic control systems. Belief systems are used to reinforce and communicate core values and beliefs. Interactive control systems implies the personal and regular interaction between employees and managers to facilitate dialogue and learning. When examining what defines interactive control, Bisbe et al. (2007) finds five properties. The first is an intense use by top management, meaning senior managements' devotion of a significant amount of time and attention related to issues concerning inputs, processes and outputs of management controls (Bisbe et al. 2007). The second is the intensive use by operating managers. The third property is the pervasiveness of face-to-face challenges and debates (Bisbe et al. 2007). There must also be a focus on strategic uncertainties, these are the opportunities and threats that can be presented when circumstances change, potentially invalidating the current business model (Bisbe et al. 2007). The final property is managers' non-invasive, facilitating and inspirational involvement, thereby empowering employees instead of constraining them (Bisbe et al. 2007). This study will not differentiate between the first two properties because the source material will not be detailed enough to make a meaningful differentiation. Instead, these two will be grouped together, being fulfilled if evidence becomes apparent that either higher-up managers or representatives of the region devote a significant amount of their time and attention related to issues concerning inputs, processes and outputs of management controls. Continuing with boundary systems, the lever defines the risks to be avoided through creating explicit limits and rules, they are manifested through codes of conduct, strategic planning systems etc. (Simons, 1994). Finally, Diagnostic control systems are used to measure outcomes according to preset standards of performance and formulate subsequent corrections, where the critical performance variables are highly influential (Simons, 1994).

Simons (2000) describes a tension between two groups of controls, the first group consisting of belief systems and interactive control systems, and the second group includes boundary systems and diagnostic control systems. The first group of controls are described by Simons as positive, they inspire creativity and the search to expand the opportunity space. Furthermore, he also alludes that these systems create intrinsic motivation through learning and information sharing. The Second group of control systems are instead referred to as negative, by constraining the search behavior and allocating scarce attention (Simons, 2000). The use of clear goals, clear limits and formula-based rewards makes this group reliant on extrinsic motivation (Simons, 2000). He describes how these two groups create a dynamic tension between innovation and learning on the one hand and efficiency and predictable goal achievement on the other, the combined use of both being important for strategic control and profitable growth. The characteristics of the two groups of levers described by Simons (2000) correspond with Adler & Borys (1996) description of enabling and coercive use of management controls. The use of Belief systems and interactive controls will lead to a more enabling use of management controls, inspiring creativity and enabling providers to better perform and master their tasks. Meanwhile, the use of boundary systems and diagnostic controls systems will instead emphasize compliance leading to coercive use of management controls.

2.3 Innovation and Management control

Fagerberg (2006) explains that it is often necessary to combine different types of resources, knowledge, skills and capabilities to go from an invention to an innovation. He continues to explain that innovation can be classified according to type. Research has traditionally focused on product innovation and process innovation, the first being the creation and improvement of products, and the latter referring to how to produce them. However, other types also exist, such as new sources of supply, exploitation of new markets and new ways to organize business (Fagerberg, 2006).

Fagerberg (2006) also discusses how innovations can be described in terms of how radical they are compared to current conditions. Incremental innovations refers to continuous improvements which by themselves might have quite little impact (Fagerberg, 2006). Radical innovations on the other hand are totally new with a more far-reaching impact (Fagerberg,

2006). Adjacent concepts in the context are modes of innovation, namely exploration and exploitation, both being important for long term survival (Bedford, 2015). Exploitation refers to the refinement of existing capabilities and competencies, whereas exploration is the search for new opportunities (Bedford, 2015). Exploration is associated with experimentation, discovery, innovation etc., while exploitation is linked to efficiency, refinement, production etc. (March, 1991). Exploitation utilizes incremental learning and repetition to innovate (Bedford, 2015). Exploration involves more path-breaking innovation by pursuing radical departures (Bedford, 2015). Firms who engage in exploitation at the cost of exploration are exposed to the risk of becoming stuck in suboptimal positions when the environment changes (March, 1991). On the other hand, firms who only focus on exploration might fail to gain many of the benefits of experimentation but still suffer the costs (March, 1991).

The question then becomes how the use of different management controls relates to innovation. Multiple researchers have studied the relationship between management control and innovation, utilizing Simons´ levers of control framework. Some have found evidence pointing in the same direction while others' findings differ somewhat. Speklé et al. (2017) examines the relationship between control, empowerment and creativity. Empowered employees being important to facilitate creativity and innovation which are important factors for progression (Speklé et al. 2017). They find that control and creativity can coexist and are not mutually exclusive, managers can thereby create a flourishing creative environment but still remain in control through the balanced use of different types of controls. They describe the enabling levers (belief and interactive) as positive in the sense that they offer employees autonomy through the freedom of selecting their course of action which will have a positive effect on creativity. On the other hand, constraining controls (diagnostic and boundary systems) provides structure through placing limits, monitor feedback etc.

On a similar note, Barros and Ferreira (2022) conclude that each lever is important in innovation management and work together. They designate the use of interactive controls and belief systems as inspirational levers which complement each other to create proactivity. Diagnostic and boundary systems in turn constitute the constraining levers which work to create alignment of innovation efforts and reduce uncertainty. Inspirational and constraining levers correspond to enabling and constraining levers used by Speklé et al. (2017). Barros and Ferreira (2022) conclude, similar to Speklé et al. (2017), that inspirational and constraining levers push the organization into different directions, where the latter helps to secure the

benefits from the inspirational levers without losing sight of organizational objectives. Speklé et al. (2017) and Barros and Ferreiras (2022) findings suggest that a more enabling use of management controls (belief systems and interactive control) is more associated with stimulating the innovative vein in the organization. Although, coercive use is still important to secure the benefits from innovativeness, giving support to the dynamic tension described by Simons (2000).

Baird et al. (2019) examine the relationship between the use of levers of control, management innovation and organizational performance. They conceptualize management innovation into four dimensions: new managerial practices, processes, organizational structures and managerial techniques. They too, examine the two combinations of control systems, enabling (belief and interactive control) and constraining (boundary and diagnostic control). Their study found that the use of enabling control is positively associated with new managerial practices, processes and organizational structures, whereas the use of constraining control showed a positive association with managerial techniques. Their findings suggest that enabling levers are overall more associated with innovation, because they are associated with three out of the four dimensions of innovation tested by Baird et al. (2019). However, the constraining levers were actually associated with one out of the four dimensions.

Bedford (2015) study examines the use of management control systems across different modes of innovation, namely exploitation, exploration and the simultaneous pursuit of these two (so called ambidextrous firms). As explained before, exploitation refers to the refinement of existing capabilities and competencies, whereas exploration is the search for new opportunities (Bedford, 2015). Bedford (2015) found that the use of interactive control is associated with higher performance for firms pursuing exploration. Boundary systems and diagnostic control was on the other hand associated with performance in exploitative firms. Finally, companies pursuing a simultaneous exploitative and explorative strategy benefited from the balanced use of interactive and diagnostic controls (Bedford, 2015). The study also showed that the beneficial control levers used in firms which pursued either an explorative or exploitative strategy had supplementary effects on performance, while the control levers used in ambidextrous firms instead had complementary effects. Baird et al. (2019) and Bedford (2015) findings somewhat problematize and give nuance to the findings by Speklé et al. (2017) and Barros and Ferreiras (2022). However, the findings do not contradict the notion that both enabling and coercive use of management control are important for successful

innovativeness. The use of coercive controls might just be relatively more beneficial when it comes to incremental innovations (exploitation) compared to radical innovations (exploration).

In Summary, the study will be using a management control perspective, instead of the perhaps more obvious use of agency theory. The reasons for this choice have been discussed above. The study will use a combination of Adler & Borys (1996) distinction between enabling and coercive use of management control systems, together with Simons´ levers of control framework. Enabling use of management control is at least in theory more directly associated with innovativeness, but coercive use is highlighted as important to secure the benefits from innovativeness. Studies have also found evidence that in a broad sense supports this view, however coercive use might also be directly associated with certain types of innovation.

3. Method

This paper will be analyzing the tender documents produced by Swedish regions to serve as contracts and guidance for primary care providers active in the region. An advantage with using public documents compared to for example interviews is that it is possible to get data from all regions, not just those that are willing to be interviewed. Regions also have the duty to supply the tender documents when asked for, provided that they are still kept in their archives. The use of public documents also decreases the chance that the authors affect the data when collecting it, called reactivity (Bryman & Bell, 2017). Another advantage is that it provides more time to analyze the collected data. The data, in the form of tender-documents, is secondary data. As the study is to analyze what these tender documents state, the study has a high reliability as they will be collected directly from the source.

It was decided to analyze 10 out of the 21 regions. This was done out of time constraints, not looking at all regions provides more time for analyzing the material. It was also assessed that a selection of regions according to size and geographical location would include a majority of Sweden's population affected by primary care, and also safeguard against geographical differences. The regions selected were the five with the biggest populations, which are Stockholm, Västra Götaland, Skåne, Östergötland and Uppsala, these regions cover about 60 % of Sweden's population (SCB, 2023). The other five were selected from the rest to get a good mix geographically and ranging from smaller to larger. These are Dalarna, Västernorrland, Gävleborg, Sörmland and Värmland. Tender documents were collected for the years 2013 and 2023 for each region to compare differences and similarities between the two different time periods. Uppsala did not have the tender documents from 2013 archived, the tender documents from 2014 were used instead. Gävleborg provided the tender documents which were used in 2010, complemented with subsequent revisions that were made up until 2013. Hence the reference to Gävleborg (2010).

The data will be collected and analyzed using a thematic analysis. Bryman and Bell (2017) describe that thematic analysis is a prominent approach when it comes to qualitative analysis. However, they also describe that there does not exist a clear, specified and common series of steps to conduct a thematic analysis, leading to differing approaches. Bryman and Bell (2017) speculate that its flexibility when it comes to analyzing qualitative data is one of the reasons behind its popularity. However, some researchers have tried to establish guidance when it

comes to thematic analysis, for example Braun and Clarke (2006) (Bryman & Bell, 2017). Bryman and Bell (2017) provide an explanation of what a theme is. It is a category identified based on the data and is related to the focus of the study, or the research questions specifically (Bryman & Bell, 2017). It is based on codes and provides theoretical insights (Bryman & Bell, 2017).

Thematic analysis was chosen because of its flexibility, as it can be adjusted to fit the purpose and the source material reviewed. It will allow the study to identify and analyze patterns in the tender document relating to innovation and the use of management control, concepts which might require interpretation to gauge their relevance. In addition, Braun and Clarke (2006) describes how thematic analysis, as opposed to other qualitative methodologies, does not require detailed theoretical and technological knowledge of approaches, and is therefore more accessible to those less well versed in qualitative research.

The study was conducted by using a theoretical thematic analysis. Braun and Clarke (2006) explain that when researchers conduct a theoretical thematic analysis it is driven by their theoretical and analytical interest in the areas. The search for codes and themes was therefore quite heavily influenced by the research questions and the study's purpose, rather than allowing the research questions to evolve during the coding process. This approach was chosen to ensure that data which was collected was relevant for answering the predefined research questions. The tender document did not use the same vocabulary as the chosen theory. It was therefore necessary that the concepts and words used in the documents were interpreted in order to translate them into the theoretical frame of reference, thereby connecting the theory and the themes. The search for themes were therefore not aimed at finding explicit expression of management controls as described by the theory, but rather to find indications that, in their meaning and context, were consistent with the use of each of Simons' levers of control, and coercive and enabling controls. It was also important to find themes that worked for all regions to ensure comparability of the findings. It is important to note that one of the drawbacks of document studies is that the bias of their writers can affect the content of the tender documents. There might also exist traces of political control in the way that the documents are written. The interpretation of key words was therefore done with caution. It should also be stressed that the document study does not take into account how the tender documents are perceived by the providers and regions, and what importance they place on the different controls used. The study does not go into detail when it comes to multiple of

the segments in the tender documents such as compensation, terms regarding staffing and medical requirements. Doing so would expand the scope of the study significantly, which because of time constraint was not possible. However, it was deemed that the analytical depth of the analysis was adequate in order to answer the research questions.

Braun and Clarke (2006) describe a guide for thematic analysis. The guide consists of six phases of analysis, the first step being familiarizing yourself with your data (Braun & Clarke, 2006). This step was conducted by first briefly reading a few tender documents to determine if the source material has the informational value required for it to have the potential to fulfill the study's intended purpose. After it was determined that the informational value of the tender documents was in fact promising, we continued to read all of the selected region's tender documents while taking notes of potential coding.

The second phase described by Braun and Clarkes (2006) is generating initial codes, which represents features of the data that appeared interesting that were then grouped together. The data was approached by keeping in mind the research questions and related theory, without being too attached to them. This process was done manually, contrary to using a software program. This was done by searching for information relating to codes and then copying extracts from tender documents assigned to specific regions and years. These were often complemented with notes explaining their relevance.

The third step is searching for themes, which includes sorting codes and subsequent data into potential themes (Braun & Clarke, 2006). Main themes and subthemes were identified, codes that did hold value but did not initially fit into a specific theme were grouped together for further considerations. Other codes were discarded.

Braun and Clarke (2006) explain that the fourth step is reviewing the themes. The evaluation questions if there is enough data to support the themes, if some themes should be discarded, combined or separated (Braun & Clarke, 2006). The identified themes were validated by reviewing the data to determine if they support the theme or not, more data were also collected when deemed necessary. Some themes were discarded based on their relevance to the study's purpose and research questions.

The fifth step is defining and naming the themes (Braun & Clarke, 2006). Names of themes and their definitions were changed many times in order to best reflect the identified theme and keep their relevance to the study. Subthemes and headlines were added and changed to increase the nuance of the data. The final step is producing the report (Braun & Clarke, 2006). It was decided that citations were to be included when exemplifying instances of uncertainty and interpretation, or to serve the purpose of increasing the credibility of the identified themes.

4. Empirical findings

This section will first present information about the primary care system. The identified themes will thereafter be presented. Simons' levers of control were used as guidance when searching for themes. This was done in order to categorize the use of different management controls in the tender documents to be able to answer the research questions. Information regarding the use of management controls in terms of being enabling or coercive was also used as guidance. The following themes and sub-themes were identified:

- Requirements to innovate.
- Common values and beliefs.
- Innovation as a core value.
- Communication and dialogue.
- Boundaries placed on providers.
    - Limitations in how to organize.
    - Limitations in adopting new technology.
    - Limitations in adopting new products and services.
- Feedback and compensation.

Analyzing the empirical findings will be done in the discussion. Referring to regional contracts will be done by writing the regional name followed by the year 2013 or 2023. This will be done for all regions regardless of when the actual contract was first published. Regional contracts used will be listed under a separate referencing list, where attachments to the contracts are included in the reference. However, quoting will be done in accordance with the rules of referencing used for the other sources, these are also included in the separate referencing list.

4.1 Primary care

Statistics available from SKR (2024) shows that the number of health centers increased from 1156 in 2013 to 1207 in 2022. However, the number of health centers per 10 000 citizens decreased from 1,2 in 2013 to 1,1 in 2023. In the year 2013, 41 % of all health centers were managed by private providers, while in 2022 this number had increased to 46 % (SKR, 2024). Although, the percentage varied a lot between regions (SKR, 2024). Table 1 shows the percentage of healthcenters runned by private providers in each of the studied regions, for the

year 2013 and 2022. data from 2023 were not available on the SKR (2024) website and the year 2022 were therefore chosen instead. The table shows that the number of health centers managed by private providers has increased over the period in all ten regions. Stockholm had the highest percentage in both 2013 and 2022, with 67 % and 71 % respectively. Dalarna had the lowest percentage in both 2013 and 2022, with 17 % and 21 % respectively. In 2013, only Stockholm and Uppsala had a majority of health centers runned by private providers. However, in 2022 they were joined by Skåne and Västra Götaland. However, the aforementioned numbers do not take into account the capacity of each health center.

The ownership structure among the private providers varies. There are both larger national health-chains and cooperatives, to regional groups as well as stand-alone providers (Janlöv et al. 2023). There are no national statistics on ownership-structure, but data from Skåne and Stockholm indicates that the most common are larger actors (Janlöv et al. 2023). There are both for profit and non-profit private actors, but non-profits are less common (Janlöv et al. 2023).

Table 1: The table shows the percentage of health centers runned by private providers, for each of the ten studied regions sorted according to alphabetical order. The data covers the years 2013 and 2022 and is collected from SKR (2024) website.

Region name	**Year 2013**	**Year 2022**
Dalarna	17 %	21 %
Gävleborg	32 %	40 %
Skåne	43 %	51 %
Stockholm	67 %	71 %
Sörmland	35 %	39 %
Uppsala	51 %	55 %
Värmland	24 %	28 %
Västernorrland	35 %	39 %
Västra Götaland	43 %	51 %
Östergötland	21 %	28 %

4.2 Requirements to innovate

The regions frequently use the word development and development-work, however it is not all that obvious what the concept actually means. The interpretation is that it includes improvements in a broader sense, which includes innovations but also other improvements which do not qualify as an innovation. Development work has therefore been considered a synonym to innovation when collecting data. However, it is important not to ignore its ambiguity, because it signifies a watered down version of the concept of innovation. Only five regions use the term innovation in their tender documents, and only in 2023. This might indicate that innovation has become more important when regions manage providers between the years 2013 to 2023. Although it is of course also possible that “innovation” has become trendier within primary care and is therefore used more without there being any actual change in practice.

All regions require that providers contribute to common or joint development efforts specified by the region, some regions provide compensation for such efforts and others do not. All regions also require the providers to conduct their own development-work and improve. Most regions explicitly state this requirement. However, a few regions do not explicitly state that providers need to devote themselves to development work on their own. It does however become obvious when reading the documents that it is in fact expected of them. The tender document also often describes certain areas of importance which providers should focus on. Providers are often required to document and disclose their improvement-efforts. Almost all regions require providers to contribute to R&D in some degree, this can include cooperating with the R&D department, encouraging employees to conduct research or being involved in research projects. Regions generally also provide R&D resources such as funds or premises which can be used by the provider themselves and/or their employees. Only in three cases it did not become apparent that the region supplied such resources, although that is not to say that they did not provide them in reality.

4.3 Common values and beliefs

The expression of common values and beliefs is mostly found in the beginning of the tender documents. There are also examples of it being present in other parts of the text. Västra Götaland 2023 stands out in having pink boxes throughout the whole document providing

different statements and values. All the regions provide different sets of goals and values that should guide the primary care providers.

Themes found in all tender documents include that the primary care should be efficient, easily accessible, equal and sustainable. That the care should be of high quality is the most prevalent theme in all documents. Cooperation is also mentioned in almost all documents. However, the focus differs with some specifying that it is between the region and the provider while others give it a broader sense that it should be both inside and outside the organization and between different professions. All tender documents describe equality in terms of sex or gender and social class. Some also bring up ethnicity and how it should not affect the care given.

Digitalization is only mentioned in a few of the documents from 2013. In 2023 all the documents mention it but give it a varying degree of importance. Two present digitalization as a major focus and that when possible, digital care should replace physical care. Stockholm (2023) uses the term "digiphysical" which states that, "*the way that the care is provided, digital or physical, is based on the medical need, the patient's wishes and efficient use of resources*" (p. 32). Another theme that is much more prevalent in 2023 is letting the patient be the co-creator in its care. The patient should be made part of the care-process and when possible, decide on which treatment to pursue. In some documents this is stated as something that increases the experienced quality of care.

The majority of regions state that the care should be safe, proactive and purposeful. They also state that the provider should focus on being long-term and cost-efficient. The provider should also see the broad picture in regards to the individuals healthcare, this relates to the providers responsibility as the coordinator of all the individuals healthcare. This focus has increased in 2023 compared to 2013. That the provider should be confidence-inspiring and that the patient should trust and feel safe is also present in many of the documents.

4.4 Innovation as a core value

Innovation is not always explicitly mentioned during the communication of core values or in other parts of the tender documents. Instead, they often use terms such as development or development-work. In 2023, six of the regions include innovation, or a related term, in a

broader sense as a core value and belief. This contrasts with other regions that only encourage innovation in specific areas, such as digitalization. In Västra Götaland 2023, it is described that efficient use of resources regarding innovation and new ways of thinking is a key to long-term success. Västernorrland 2023 refers to a separate plan called “God och nära vård 2030 (2023)” which outlines several goals, such as quality, sustainability and digitalization, that all innovation should strive towards. Värmland 2023 also refers to a long-term plan which describes how innovation is a key to success in achieving their goals, especially regarding sustainability and digitalization . Uppsala 2023 states that all suppliers have to conduct a continuous development work which is in line with the region’s definition of quality. Uppsala’s 2023 definition of quality is the provider's ability to serve the patients and their family’s needs. Skåne 2023 states that one of their guiding principles is to welcome new ideas. They also state that developing new ways to organize work and efficiency should be encouraged. Gävleborg 2023 has three guiding principles which are to focus on the individual, ability to improve and lastly trust and cooperation. The innovation part is represented through the ability to improve, they state that they encourage learning and development to increase quality and provide a diverse selection of providers which gives greater opportunities to choose for the patient.

In 2023, three of the regions include innovation as an important value, but only regarding specific areas. Stockholm and Östergötland 2023 encourage it regarding digitalization where the goal is to be able to provide healthcare more efficiently compared to physical visits. Dalarna 2023 encourages it when it comes to research and describes it as a key focus area to develop efficient, equal and available healthcare. Sörmland 2023 provides a list with areas that they call basic quality demands. This describes how all healthcare should be knowledge-based and purposeful, safe, centered on the individual, equal, delivered within a reasonable timeframe and efficient. When describing these characteristics innovation or improvements is mentioned or that they should try new methods. Development is mentioned in other parts, but only regarding research and medical treatments.

In 2013, innovation was mentioned as a core belief of three regions. Värmland 2013 states that development and new ways to think should be the hallmark of the entire organization. Furthermore, every leader has the responsibility to stimulate workers to participate in a long term and sustainable work that develops the work and makes it better. Gävleborg 2013 has a section about how choice when it comes to primary care will lead to continuous

improvements. Dalarna 2013 has a part in their vision that says the providers are responsible to take part in the development of effective “healthcare-chains”. Five of the regions did not mention innovation or any related term when expressing the core values and beliefs in 2013.

4.5 Communication and dialogue

Regions often emphasize the importance of cooperation between healthcare providers and other social actors. This includes general cooperation to create a good experience for the patients and a coherent care chain. However, it also includes participation in development projects, working groups and other joint efforts to improve. See the example from Östergötland 2013 below.

“Based on its broad mission, the provider must cooperate with care neighbors and other social actors. The provider must cooperate with other actors in the common improvement work, which may include participation in working groups on care processes, development projects etc. The provider can undertake an extended responsibility for the joint improvement work.” (Östergötland, 2013, p. 9)

It becomes obvious that dialogue between providers is encouraged and to a large degree compulsory. However, it is often less obvious exactly what role the region plays in all these interactions if they are an active part or not. See example from Västernorrland 2013 below, concerning environmental representatives meetings. Although, in some contexts it becomes clear that the region is represented in the dialogue and plays an active part, see example from Gävleborg 2023 below.

“The provider must participate in the county council’s environmental representatives meeting (or equivalent) at least once a year.” (Västernorrland, 2013, p. 27)

"For sustainable work, dialogue is required between healthcare providers within Hälsoval Gävleborg (producers) and the Health office (representatives of the financier/client). Annually, therefore the health elections office calls for:

- *Industry council, where representatives from the care providers participate*
- *Dialogue meetings, where managers from different levels in the operations participate*
- *Meetings with medical advisors*
- *Meetings in collaboration area*
- *Business visits/audits*
- *Information meetings"*

(Gävleborg, 2021, p. 12)

One area where dialogue between the provider and the region becomes evident is during the follow-up, where the dialogue in itself is often depicted as an essential feature. Although, most often it does not become clear how frequent this type of interaction is. Some regions express a commitment to carry out follow-up dialogue a minimum number of times a year, like the example of Gävleborg 2023 below. While others do not commit to a specified number of meetings but highlight their use of dialogue, see quote from Uppsala 2023 below. On the whole, a strong majority of regional contracts explicitly mentions the use of dialogue in their follow ups, out of these only a few specify a minimum number of meetings ranging from one to two a year. In a few contracts it is not explicitly stated that dialogue is part of the follow-up, however it can't be ruled out that they do carry out meetings.

"The goal is for dialogue with the care provider to take place once a year. The Health Elections Office is responsible for calling the follow-up. In addition to the annual review, the Hälsvalskontoret can call for follow-up dialogues in specific areas, for example drug prescription." (Gävleborg, 2021, p. 24)

"Region Uppsala is responsible for following up on how the providers fulfills the Agreement and how quality is met. Region Uppsala applies a trust- and dialogue-based approach follow-up model with continuous contact." (Uppsala, 2023, p. 24)

4.6 Boundaries placed on providers

This section includes sub-themes concerning boundaries placed on providers which can potentially hinder innovation.

4.6.1 Limitations in how to organize

All regions include sections about how all care must be clinically approved and based on research. However, some regions also offer more general statements regarding how the providers should be organized and place limitations on what procedures should be used. Östergötland 2023 states that all providers must use the “integrerad beteendehälsa” (IBH) or an equivalent method, which is a preventative method, when dealing with people with risk of mental illness. Another more mixed example is from Värmland 2023 where they state that the providers must follow national and regional guidelines and procedures. However, they also state that they encourage new methods and routines, but they must be approved by the region if they are not based on science or proven experience. Skåne 2013 has one of the more allowing statements. They write that the providers are given a large degree of freedom to shape the care based on the requirements listed. Furthermore, diversity and freedom will benefit both patients, create more attractive workplace environments and improve recruiting. This section is not present in Skåne 2023. Which is a general finding regarding similar sections praising freedom and choice found in the documents in 2013, but not in 2023.

Regarding the use of subcontractors all the regions allow it but place several restrictions on their use. About half of the regions allow it while placing a number of terms and force the provider to report to the region which subcontractor they are using and why. The other half also place terms and in addition require the providers to get permission for each new subcontractor they want to employ. Sörmland 2023 are unique in that they require permission if the subcontractor will be used for more than 20 hours per week. A trend can be seen in that three regions have gone from not requiring permission to requiring it, while none have gone the other way.

In all tender documents, the provider must offer a permanent contact for the patient if they ask for it or if it is deemed necessary. This is also written in Patientlagen (2014:821). Sörmland 2023 demands that the provider sign a collective agreement, while all the other regions state that they should sign one. The Swedish word for should used is “bör”, which generally holds the meaning that it should be done unless there are significant reasons not to.

Six regions allowed the use of branches in 2023, while three allowed it in 2013. The branches are allowed to offer a more limited selection of the services normally required to be offered by the tender documents. The purpose of these branches is to offer services in more remote locations to improve accessibility. Västernorrland 2023 specifies that the purpose is only to improve care and must not be to receive economic benefits or other business reasons and that the subsidiaries do not receive compensation. Other terms include limiting opening hours.

All regions state what capabilities the provider must have. The majority also include specific requirements regarding personnel. These include specifying the qualifications of the nurses and physicians hired. The most limiting requirement regarding this was found in Östergötland 2013 which requires that there must be a minimum of two physicians at each health-center, while at least 50 % of the physicians must be specialized in general-medicine.

The opening hours required vary between the regions. Specifying that they must be open between certain hours all working days of the week was done in four regions in 2023 and two in 2013. Another system is to specify a set number of hours they must be open which varies between 48 to 40 hours per week, this was done in two regions in 2023 and four in 2013. Uppsala 2023 has their own boundaries which state that providers with less than 4000 listed must be open at least 40 hours per week and those with above 4000 listed must be open at least 45 hours per week. In 2013 four regions had no requirements regarding opening hours and in 2023 two regions. Värmland 2013 and 2023 have no requirements but encourage providers to adapt to the needs of citizens and if possible have opening hours that are different from regular office hours.

Most regions have sections about how cooperation between providers, the regions and other parts of society is important. Some regions, such as Västernorrland 2023 have voluntary groups where providers can share knowledge and experience with each other to benefit everyone. Värmland 2023 takes it further by forcing primary care providers to adopt certain innovation strategies and then making it mandatory for them to share the results both with the region and the other primary care providers.

4.6.2 Limitations in adopting new technology

All the regions have some sort of boundaries regarding digital systems. All regions in both 2023 and 2013 have some mandatory IT-systems that the primary care supplier must use, except Västra götaland 2013. These include that they must be connected to the digital infrastructure that the regions have. This infrastructure is used for, among other things, shared medical records. The regions use different systems for this, the most common being “Sjunet" and "Cosmic ". Aside from the infrastructure, the regions have a varying number of mandatory IT-systems and programs. Almost all regions also offer voluntary systems. The regions also offer support for both mandatory and voluntary systems. In 2013, two regions specified that the mandatory systems are paid for by the regions, while the voluntary ones are paid for by the provider. Sörmland 2013 was unique in that they also mandated that the provider must rent PCs from them, while simultaneously stating that they want to provide as much freedom as possible when it comes to IT as they are dealing with private companies. All regions also state what capabilities the providers must fulfill regarding IT, these include a joint medical records system and being able to communicate digitally. Västra Götaland 2013 does not have any mandatory or voluntary systems, they instead only list what capabilities the providers must have. In 2023 they had added a mandatory joint medical records system, which they had to due to the law implemented in 2023, (Riksdagen, 2022). They also implemented one voluntary system and stated that suppliers had six months to execute new demands regarding IT. All regions also require the providers that all digital information must be stored safely with regards to patient confidentiality. Generally, the trend can be seen as the regions becoming more controlling, adding more required systems and giving less freedom of choice to the providers.

4.6.3 Limitations in developing new products and services

All regions have boundaries placed on what capabilities the providers must have. However, they vary in how detailed they are or whether they only specify what type of care they must be able to provide, or also what type of education the staff must have and what equipment must be present. For example, in Västernorrland 2013 all primary care providers where required to have a nurse with competence in diabetes. Stockholm 2013 had an economic incentive to give care to those newly diagnosed with diabetes, but to receive the fund the nurse conducting the care required 7,5 ECTS-points in diabetes-care.

The regions allow the providers to provide other services which are not included in the services that they must provide. They all apply different regulations regarding this however. A number of them state that these services must be clearly separated from primary care. This includes that it must be listed separately when it comes to accounting. Sörmland (2023) states that, "*if the primary care provider is conducting other operations it will be economically and qualitatively separate from the healthcare-center described in this rule-book*" (p.17). Aside from this, it is not further developed what is meant by keeping the services separated. Another is that it must not adversely affect the services that they have to provide. The providers are free to set the price of these services, Östergötland 2023 states that the providers must also clearly inform the patient that the service is not part of the primary care and is not financed by the region. Västra Götaland 2023 demands that before the providers start offering a new service, they must first consult it with the region. The services provided must not adversely affect the image of the primary care according to Östergötland 2023. No significant differences have been noted between 2013 and 2023 in all cases.

4.7 Feedback and compensation

The data include the intended purpose with follow-ups, the nature and content of follow-ups, and what information is communicated to providers and citizens. The results also include types of metrics used as a basis for the compensation received by providers, to more easily identify critical performance variables.

Most regions explicitly communicate their intended purpose with follow-ups, however in a few contracts the purpose is not stated. The most common purpose is to verify that the contractual obligations are fulfilled by the health center and that the basis for compensation is correct. It is also common to refer to development as a purpose, however this often refers to the development in primary care in general in the region and seldom emphasizes the development for the specific provider. This phenomenon is exemplified below with a quote from the region Västernorrland's tender document. However, there are also some cases where the contract references the development in the individual healthcenter, see the quote from the region Västra Götaland below. It is also common to refer to the goals being quality control and checking the level of goal-fulfillment. It is important to note that it is often a combination of these examples that serves the purpose, thereby making it multidimensional, see quote from Västernorrland 2013 below.

"*The purpose of follow-up is to follow up the care provider's commitment according to this rulebook with appendices and the agreement, the degree of goal fulfillment and contribute to the development of care i Västernorrland county."* (Västernorrland, 2013, p. 40)

"*Indicators must be linked back to the health centers that were part of the operations' own improvement work."* (Västra Götalandsregionen, 2013, p. 37)

It is a consistent theme throughout all regions, both during 2013 and 2023, that providers need to supply national and local records and databases with information and data. They also need to provide the region with information not covered by such databases. Overall, providers need to be helpful in providing data to certain actors when asked for it.

There are some differences in the classification of follow-ups between regions, but everyone expresses that they perform ongoing follow-up based on what appears to be a wide range of data. Regions generally use a variety of methods in performing follow-ups, it includes examinations, evaluations, planned and unplanned visits etc. Regions use a so-called follow-up plan, but some reserve the right to depart from this plan. In most contracts it does not become obvious how regular the ongoing follow-up is done, and in some cases it appears like it is quite seldom, like the example below.

"The Västra Götaland region continuously monitors, at least once a year, that providers fulfill their commitment and maintain the quality that follows from the Requirements and Quality Book." (Västra Götalandsregionen, 2023, p. 64)

In a majority of accreditation requirements it is mentioned that the region performs deepened follow-ups as a complement towards the ongoing. However, the phenomenon of a deepened follow-up is more common in contracts from 2023. It is often explained that deepened follow-ups are performed when there are indications of faults based on the ongoing follow-up or other sources, thereby looking into a potential problem or fault in more detail and depth . However, a few regions also express that they are both proactive and reactive during their deepened follow ups as well.

All regions establish the right to perform different types of audits, such as business audit, medical audit and audit of the provider's quality management system. The type of audit mentioned in the accreditation requirements varies somewhat between regions, but there is generally not much change in this area between 2013 and 2023. It is expressed that the role of the region's auditors is to audit how the providers conduct their business and fulfills the agreement, see example from Östergötland 2013 below.

"The region's auditors are tasked with auditing all activities conducted within the committees' area of activity. The role of the region's auditors in contracts with providers is to review how the relevant committee handles its task of following up and evaluating the contractual relationship." (Östergötland, 2013, p. 24)

The majority of rapports highlight the use of meetings and dialogue when providing feedback and discussing results from the follow up. Many of them also emphasize dialogue as an important factor of successful follow ups and feedback. It is also quite common to provide health centers with the results of the follow up via web-based systems or sending them reports. However, these often only include a selection of indicators and information and regions reserve the right to choose the content shared and when it is shared. See the two examples below from Värmland 2023 and Gävleborg 2013. In other cases it is not apparent based on the tender documents how much of the collected data from the follow-up then becomes available to the provider, by not mentioning it or using vague language. There is also some variety when it comes to the information that is available to citizens. Some regions express that a selection of indicators becomes available to citizens, while in other cases it does not become clear or is not mentioned.

"Region Värmland owns the report that is the result of the operational follow-up and is responsible for submitting and communicating it at a time deemed appropriate." (Värmland, 2023b, p. 18)

"The county council undertakes to feedback a selection of follow-up variables via a web-based system, so that the health center can compare itself with other health centers within Health Choice Gävleborg." (Gävleborg, 2009, p. 25)

Providers are not allowed to freely price services which are included in the contractual assignment. Instead, the region pays out compensation relating to the execution of the assignment. The compensation generally consists of compensation based on risk-adjusted compensation, commitments, production of services, use of resources etc. However, it is also very common for regions to establish compensation based on the level of quality, goal fulfillment and other improvements. Some regions, such as Stockholm 2023, also incorporate the use of financial penalties if goals are not fulfilled. It is often only a selection of the indicators, data and information relating to quality and performance collected for the follow-up which is then also compensated. In general, providers also receive compensation when participating in development work and programs when conducting research.

4.7 Summary

The beliefs promoted the most by the regions are efficiency, equality and safety. Cooperation, digitalization and co-creation are terms and values which have emerged or become more common in 2023. Innovation is another term which is mentioned more in 2023. One development is that some regions give specific areas where innovation is needed, mostly digitalization. Throughout the documents, a term that is used more compared to innovation is research and development-work. Dialog and cooperation varies between mandatory and voluntary meetings. It is unclear exactly which actors participate in these meetings and how often they occur. The nature of the meetings is also not clearly stated. The regions collect much information during follow-ups, some used as feedback.

There are limitations placed on developing new methods, these include that they must be approved by the regions and that they need to be based on research. However, some documents also include that they encourage new methods. The regions also have mandatory or voluntary meetings where new methods are shared. In 2023 there were more regions who allowed more freedom regarding using branches and less strict specific personnel requirements. The requirements regarding specific opening hours have become stricter. Furthermore, the development regarding digital systems is that the regions are less strict overall, but there are areas where mandatory systems have become the norm such as digital and shared record-keeping. Services which are outside of the required list are allowed but have several restrictions such as that they must be separated from the rest of the operations and must not have adverse effects on the mission.

5. Discussion

This section will analyze the data and discuss the findings to answer the three research questions:

1. What types of management controls do the tender documents favor?
2. Have the management controls in the tender documents changed between the years 2013 and 2023?
3. How do the tender documents affect the innovativeness of primary care providers?

The discussion will begin by identifying the use of each of Simons' levers of control in the tender documents. It will then continue by weighing the two groups of levers described by Simons (2000) to determine if the use of management controls in the tender documents is coercive or enabling. The discussion will then continue to analyze if the use and nature of the management controls have changed between the years 2013 and 2023. The discussion ends with an analysis of how the management controls used in the tender documents can affect innovation.

5.1 Do tender documents favor enabling or coercive control?

This section will begin by analyzing the apparent extent of Simons' levers of control in the regions' tender documents. The combined use of these levers will then be analyzed to conclude if the tender documents favor enabling or coercive control.

5.1.1 Interactive control

The data reveal that dialogue occurs between the region and providers and that many regions express the importance of communication and dialogue. The question then becomes if this communication has the properties described by Bisbe et al. (2007) for it to count as interactive control. We will begin by analyzing if part of the feedback and audit system is interactive then continue to analyze other potential forms of interactive control. The first two properties described by Bidbe et al. (2007) involve the region's devotion of a significant amount of their time and attention related to issues concerning inputs, processes and outputs of management controls. Only a few regions specify a minimum number of feedback-meetings a year, ranging from one to two. The low number of follow-up meetings pledged by the region indicate that there are in fact quite few face-to-face meetings between

the region and providers concerning feedback. It is therefore improbable that the communication by these regions count as a significant devotion of time. The other regional contracts do not specify how frequent the feedback meetings are conducted and it therefore becomes difficult to determine if the first two properties are fulfilled. The five regions studied by Glenngård and Anell (2021) and the two regions studied by Arvidsson et al. (2021) conducted feedback meetings annually or even less often, in combination with this paper's findings, serve as an indication that such meetings seldom occur in general. The last three properties of interactive control described by Bisbe et al. (2007) are pervasiveness of face-to-face challenges and debates, focus on strategic uncertainties, and non-invasive, facilitating and inspirational involvement, thereby empowering providers instead of constraining them. The feedback is mostly focused on contractual obligations, this becomes apparent from the stated purposes and indicators used. Although other purposes of feedback are expressed such as quality control and development, these appear to be less important. The study did not find data which reinforce that the last three properties of interactive control are fulfilled to any significant degree. Traces of these properties might occur, such as following up on strategic measures, but not to such a degree that they are considered dominant enough. It is therefore concluded that the follow-up and audit does not qualify as interactive control. This is perhaps not that surprising when it comes to private providers, because after all, they are not owned by the region and are instead self-governing. The relationship might therefore not be close enough that interactive control becomes a viable option.

When it comes to other types of interactions between the region and providers such as visits, dialogue meetings, environmental delegate meetings etc. It becomes less obvious if the requirements of interactive control are fulfilled in these settings. Some regions clearly express that the region plays an active role in these interactions, however in some cases it is less obvious. The extent and frequency of these meetings is also unclear. The conclusion drawn from the data is that meetings which are described as communication based, argumentative, focusing on strategic areas, focused on learning and where the region plays an active part are more likely to be, or at least closer to being interactive control.

5.1.2 Belief systems

Moving on to the use of belief systems, they are most often found in the beginning of tender documents but can also be found throughout the documents. Common values communicated are efficiency, quality, equality, cooperation and safety. These work to reinforce core values which serve to influence providers so that their behavior and actions are aligned with those desired by the regions. Although there is some variety when it comes to the use of belief systems in tender documents it is concluded that regions devote relatively little attention to them in their tender documents. This is based on the fact that they mainly occur in the beginning of the documents and are not reinforced throughout the tender document, thereby reducing their importance. The exception to this is Västra Götaland 2023 that reinforces the values throughout the documents with pink boxes of text. It could be questioned whether or not this is more effective as it becomes harder to get the full picture of the belief system compared to having a more coherent text stating it. On the other hand, each value or group of values might become more reinforced and emphasized if they are scattered and repeated throughout the document. Overall, the belief system appears more enabling when looking at the core values and the overall language used.

5.1.3 Diagnostic control

The gathering of information concerning providers activities and performance is quite extensive. It appears like healthcenters need to provide regions with a lot of data and information which are then processed and analyzed by the region. In many cases it does not become apparent how much of the collected data is then used as feedback for the provider. In other cases, it is specified that a selection of indicators are used. Although it is apparent that the measuring of outcomes is quite advanced and extensive in all regions, it is not all that apparent, based on tender documents, how much of these are used as feedback to formulate corrections. The feedback and audit is mainly focused on checking that contractual obligations are fulfilled and to verify that the basis for compensation is correct. Although almost all regions state other purposes as well such as quality control and helping in development, it became evident that these factors are less important. This is also concurrent with findings from Arvidsson et al. (2021) and Glenngård and Anell (2021). This indicates that a lot of the measurement of outcomes serves the purpose of auditing rather than used as management control. This is to some extent not surprising because the primary care market can be described as a quasi-market (Glenngård, 2016). Monopolistic state providers are

replaced by competitive providers, but the providers cannot compete in terms of price because consumers' purchasing power is expressed in terms of earmarked budgets instead of in monetary terms (Glenngård, 2016). Regions must therefore audit primary care providers in order to ensure that they provide services according to the contract and that they receive the proper compensation. All information and data collected therefore becomes superfluous when it comes to giving feedback to providers.

It is possible to look at the compensation to determine if certain performance variables are rewarded which can reveal the use of diagnostic control. Janlöv et al. (2023) has established that the majority of the compensation is risk adjusted for listed patients. It also consists of performed commitments and services, use of resources etc. These represent compensation based on performing the stated assignment, which is a necessity in a quasi-market, because providers do not get paid by patients directly, but instead by the region. Although, it is also common that providers may achieve compensation based on performance relating to quality and/or goal fulfillment. Some regions also incorporate the use of penalties for not achieving set goals, which arguably makes the use of diagnostic control systems even more controlling and coercive.

5.1.4 Boundary systems

The use of boundary systems becomes very apparent in the tender documents. Creating boundaries that force the providers to work a certain way is a dominant theme in the tender documents. Opening hours is one example of this, it is an easily understood concept for the patient, if the providers could offer a different set of openings hours, the patient could choose the one that best suits their needs. This in turn allows providers to be innovative when it comes to opening hours. It is however understandable that the regions place more rigid boundaries since they want to make sure of the primary care's availability. Other examples of these restrictions are that not all regions allow branches, regulating the composition of staff, mandating collective-agreements, requiring permission for the use of subcontractors and having mandatory IT-systems. The regions also force the providers to use certain methods when it comes to attending patients, examples of this are that the patient should be a co-creator and be offered a permanent contact. When the regions mandate that a certain method is to be used, they create a boundary that can inhibit innovation. At the same time, it is understandable that they want to promote a certain method that they perceive as good.

Furthering its use could also lead to increased insight into developing the mandated method. This is a top-down approach, which could give the signal of a lack of trust both for the providers and the professionals, if it is perceived this way it has a negative effect on innovation among the primary care providers.

Collaborating is promoted heavily in the belief-systems, especially in 2023. It can also be seen in the boundary-systems. Mandating that the providers must share insights with the region and providers removes the incentive to use resources to promote innovation, since the competitive edge that would give an economic incentive is lost, as all others also have the same information or knowledge. Here, there is a goal-conflict between providing the best, equal care possible to the population, while still giving economic incentives to innovate and change for the providers.

5.1.5 Enabling or coercive?

When weighing the prevalence of different control systems, it becomes apparent that regions favor the use of coercive controls compared to enabling ones in their tender documents. Thereby relying on a top-down approach which emphasizes centralization and compliance, rather than an enabling approach towards private providers. The lever with the most emphasis is boundary systems, followed by diagnostic control, then belief systems and finally interactive control. It should however be stressed that tender documents in many cases lack some detailed information relating to diagnostic control and interactive control.

5.2 How have the management controls used in tender documents changed over time?

There existed an emphasis on coercive control compared to enabling control in both 2013 and 2023. Where the comparable significance of each lever has remained the same, the most emphasis has been on boundary systems, followed by diagnostic control, then belief systems and finally interactive control. However, the content and strength of each lever has changed somewhat over the time studied. Three of the regions in 2023 specified that digitalization was the area where innovation was needed, while none did in 2013. This could on one hand be seen as promoting a key area, which could benefit innovation. But at the same time there is a risk that giving a focus area could be seen as coercive and a form of top-down control. As stated by Glenngård and Anell (2021), top-down control is the common method to promote

innovation in healthcare. While it is the common form, promoting a more bottom-up approach could be a way to promote innovation from the practitioners themselves. Therefore, the use of a focus-area clashes with the statements regarding promoting innovation from within the organizations.

Another issue with giving a focus area is that in a way it defeats the purpose of the choice-reform. It was implemented to let the free market innovate and find solutions, which in turn would create a diverse selection to choose from for the citizens. But when steering the providers in a certain direction, they create a less diverse offering and also does not let the market find its own areas which can be improved. This increase in steering is an overall trend in the documents regarding for example providing a permanent contact for the patients and specifying specific methods for treating the ill. When looking at 2013, only three regions mentioned digitalization in their belief-system, this indicates an inability to predict which areas hold the greatest potential for innovation. It should be noted that most private providers probably did not either, but they do not hold the same power to control that the regions do. Little evidence was found in the tender documents that demonstrated a change in the use of interactive control, both in 2013 and 2023.

Not much change was found when it comes to the level of the use of diagnostic control systems in the tender documents between 2013 and 2023. However, the use of so-called deepened follow ups was more commonly used by regions in 2023 compared to 2013. They serve the purpose of looking into potential problems or faults in more detail and depth when indications of faults based on the ongoing follow-up or other sources occur. This might imply that the follow-up system has become more dynamic and less rigid by not just following a predefined plan and instead being more reactive to the environment. Although, it is still uncertain if the deepened follow-ups can be classified as diagnostic controls or if they just serve the purpose of monitoring that providers adhere to the contractual obligations. Janlöv et al. (2023) have found that the use of compensation based on reimbursements for visits or process measures, pay-for-performance based on indicators intended to reflect availability and process quality, and finally cost responsibility for listed patients' use of primary care at other providers, have decreased over time. This might indicate that the use of critical performance variables has decreased during the period or that their importance has diminished because of their declining portion of the compensation.

Creating boundaries that force providers to work a certain way has overall increased from 2013 to 2023. Opening hours is one example of this, where the most restrictive method, which is to specify certain opening hours, has increased from two regions to four over the period. Opening hours is an easily understood concept for the patient, if the providers could offer a different set of openings hours, the patient could choose the one that best suits their needs. This in turn allows providers to be innovative when it comes to opening hours. It is however understandable that the regions place more rigid boundaries since they want to make sure of the primary care's availability. On a free market there should not be a need to regulate the opening hours, the consumers would pressure it to be open when they want them to. The quasi-market, described by Glenngård (2016), could be the reason for many of the boundaries found in the tender documents. It has led to a retention of power in politicians and public officials, when decreasing their power and influence was one of the goals of the choice-reform (Socialstyrelsen, 2016). Other examples of these restrictions are that not all regions allow branches, regulating the composition of staff, mandating collective-agreements, requiring permission for the use of subcontractors and having mandatory IT-systems.

5.3 Implications for innovation

The region's use coercive control more compared to enabling control in their tender documents, both in 2013 and 2023, Thereby relying on a top-down approach which emphasizes centralization and compliance, rather than an enabling approach towards providers. What implications does this have for innovation? Findings from Speklé et al. (2017) and Barros and Ferreiras (2022), and to some degree Baird et al. (2019), indicate that such use would suppress the innovative ability of providers. Simons (2000) express the view that an emphasis on coercive levers would shift the focus to efficiency and predictable goal achievement, at the cost of innovation and learning. This creates an inconsistency in what values the regions emphasize as important, namely information sharing and learning, and the effect of the controls they use. The inconsistency can possibly create confusion and resentment from providers, which will counteract cooperation between providers and the region alike.

On the other hand, findings from Bedford (2015) show that the emphasis on coercive controls would be beneficial for providers pursuing the exploitative mode of innovation. These providers would expand their capabilities in incremental learning and increase efficiency and

refinement. Bedford (2015) studies how the use of management controls affect performance in individual organizations, however the results might not be applicable in this particular setting. An individual provider who pursues exploitative innovation would, according to Bedford (2015) benefit if its management uses coercive levers. However, the boundaries and desired outcomes set by the region might not align with those desired by management of the provider. So even in these cases can misalignment occur between the management control used by management and those used by the region. It is therefore uncertain if the region's use of coercive controls would be beneficial even to exploitative innovation, it can potentially instead work as a barrier. When it comes to providers wanting to pursue the explorative mode of innovation, it is inconceivable that they would benefit from the heavy use of coercive control, because neither Bedford (2015), Speklé et al. (2017), Barros and Ferreiras (2022) or Simons (2000) support this.

The goal-conflict described in Skoog (2018) can be used to understand the findings regarding the emphasis on coercive controls. The regions want the providers to both be innovative, while still providing equal care to all. But to be innovative can in many cases clash with equality. The boundaries placed on the providers, for example regarding trying new methods, further inhibit innovation taking place among the primary care providers. Based on the findings, innovation is not prioritized compared to other values such as efficiency, equality and safety. It is logical, from both perspectives, the region and the providers will receive much more criticism if safety is not achieved, but much less if innovation is not achieved. As innovation has a cost, unless it is successful it can also easily be criticized as a waste of tax-payer money. A problem that does not exist in the same way on a free market governed by the principles of capitalism. These factors combined further show why the regions would want to engage in stricter controls that do not benefit innovation. There might also be rational arguments behind the use of certain boundary systems, such as requirements to use certain IT-systems. Requirements to use common IT-systems can have possible advantages; providers might gain advantages from economies of scale if the region buys or develops one system that everyone uses, or transferability of information regarding patients might be done more efficiently leading to better care. Condemning the use of coercive controls should be done with care, because they might work as a positive force in certain contexts.

Equality is interesting out of the values, promoted in the belief systems, as unlike the others it does not provide a financial incentive in itself, which is important for the private providers.

Increasing your efficiency can help to increase financial gains through higher profit margins or increased revenue. Cooperation could also lead to financial gains. But making care more equal does not have a clear financial benefit for the provider. This could mean that to promote innovation in this area, the controls should be more coercive. Another area where coercive controls could be effective to promote innovation is readiness for crises such as pandemics and wars, as preparing and being innovative in these fields also does not hold a clear financial reward. These are however areas where it would be more intuitive to strive for explorative innovation and then switch to exploitive when the crisis hits. This does however not align with Bedford (2015), Speklé et al. (2017), Barros and Ferreiras (2022), Simons (2000) as they do not support using coercive controls for supporting explorative innovation, creating a controlling dilemma for the regions. It is important to note that public or non-profit providers' financial goals probably differ from for-profit providers. Their goals might instead be to end up with a financial result close to zero, to indicate an efficient use of funds. They might therefore be more inclined to innovate in areas where the financial incentives are weaker, compared to for-profit providers.

The voluntary and mandatory meetings where providers share new methods and other experiences with each other should have a positive effect on innovation overall, by promoting learning. However, those who are for-profit also have an interest in gaining a competitive advantage. When being forced to share their innovations with their competitors, one of the incentives to innovate is removed. On the other hand, the region wants all care to be as good as possible and equal, allowing a provider to keep an advantage does not necessarily achieve this since the advantage is not shared with the other providers. The conflicting logic highlights one of the main problems with the choice-reform, which is to balance the free-market logic with those of the public-sector. For those who are non-profit, the cooperation both mandatory and voluntary should have a positive effect on innovation as they do not have an interest in gatekeeping their innovations. Cooperation might however have a net-positive effect for all providers since they might lack the time, resources and size to pursue innovation. But as most for-profit providers are larger organizations (Janlöv et al. 2019), this may not be the case.

The phenomenon where regions require providers to innovate is another area of interest. On the one hand, such requirements can be perceived to be quite coercive, especially if they are paired with requirements or instructions of what types of innovations are required. However,

if the requirement to innovate is paired with interactive control systems focused on learning where providers are given more freedom, it may be perceived as facilitating innovation. One general suggestion that can be made to lessen the negative effect of the management controls on innovation, is to increase the use of interactive control, especially when it comes to the design of tender documents. Tender documents could be constructed more in terms of a button-up approach, as opposed to the current top-down approach, and providers' needs would be better taken into account. This arguably holds true for both explorative and exploitative modes of innovation. It should however be stressed that this study only looks at the apparent use of management controls based on the tender documents and does not take into account other forms of management control and not even how the tender documents are perceived by providers or the regions themselves. Any recommendations should therefore be made with caution.

6. Conclusion

This study shows that tender documents favor coercive control compared to enabling control. The emphasis on coercive control holds true both for the years 2013 and 2023, however the use and content of each specific lever of control have changed somewhat. Finally, tender documents do to a large degree hinder explorative innovation due to their emphasis on coercive control. However, this emphasis can potentially be beneficial for exploitative innovation.

Furthermore, the paper gives insights to regions about the nature of their tender documents in terms of management control and how this might affect the innovativeness of providers. Likewise, citizens and professionals get insights into what effects the tender documents might have on innovation from a management control perspective. Actors who consider or plan to establish themselves as a primary care provider get insights into the management controls in the tender documents. While current providers will have more insights into the management control used by the regions as they experience the whole package and not just the effects of the tender documents, this study's findings might therefore be less impactful for them.

It was concluded that a management control perspective can be used to analyze the tender documents. It must however be emphasized that the tender documents constitute one part of the management control package used by regions. It can therefore not be concluded if the regions on a whole use more enabling or coercive control and its effects on innovation just based on this study alone. It does however give insight into the phenomenon and increases the general knowledge surrounding it.

6.1 Methodological criticism

The thematic analysis is based on the ability of the authors to identify the themes of interest and relevance. One shortcoming of the method is therefore that a replication of the study might conclude in other themes being identified, potentially disputing our conclusions. The thematic analysis was driven by the authors theoretical and analytical interest in the area, it was therefore influenced by the research questions, the study's purpose and the theoretical framework. An inductive process could reveal insights important to the knowledge of the phenomenon which were lost using a theoretical thematic analysis.

One further limitation with the study is that it only analyzes the use of management controls in the tender documents. It does not take into consideration other forms of management controls and how the tender documents are perceived by providers, practitioners and the regions themselves. For example, providers might give very little notice of certain values conveyed in the belief systems, while other values are perceived as very important. This study does not include such nuances, which can be quite impactful when making conclusions. There might also exist differences in the use of management controls towards public providers and private providers, a factor which this study does not take into account. The study does therefore only give partial insights into the management controls used by the regions in relation to providers, and therefore needs to be complimented by other studies to give a more complete picture.

This study only collected data from 10 out of the 21 regions. Insight from eleven of the regions were therefore not included, which might have affected the conclusion compared to if all regions were analyzed. The study also only includes data from two years, 2013 and 2023. An analysis of more years can give more nuanced insight into how the use of management controls have changed over time. Finally, one general shortcoming with studying documents is that they might be subjected to the bias of its writers or in this case, even the politicians.

6.2 Further research

Future studies could replicate this study by using thematic analysis or other types of qualitative analyses to validate the results or provide different perspectives concerning the tender documents. Studies could also examine other parts of the management control package and compare results to conclude the aggregate effects on innovation that the management controls utilized by the Swedish regions have. These studies could also incorporate more diverse factors such as political leadership or population size to determine if these influence the controls used. One more area of interest is the difference in attractiveness for private providers to establish themselves in different regions. As seen in table 1, there are differences in the share of private health centers, which indicate differences in attractiveness.

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