



School of Business
Economics and Law
GÖTEBORG UNIVERSITY

F AE50E Master Thesis – Management Accounting

Drifting Measures

How performance measurement is perceived at different hierarchical levels of a public mental healthcare organization

Gothenburg the 9th of June 2014

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Preface

This master's thesis, consisting of 30 European Credits, was written during the spring semester of 2014 for the Business Administration Program of Management Accounting at the University of Gothenburg, School of Business Economics and Law.

The authors would like to thank all the respondents involved in the research for their participation during the interviews and for giving valuable assistance in our search for additional information. Without your contribution this study would not have seen the light of day. The authors also send out a special acknowledgement to our supervisor Universitetslektor, Mikael Cäker. We are more than grateful for the guidance that we have been given throughout the whole semester. Without your support this thesis would not have been what it is today.

Gothenburg, the 9th of June 2014

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Abstract

The demand for public healthcare services has increased rapidly over the last decades, which has entailed an amplified pressure on the healthcare organizations to increase the efficiency of care. In the 1980s, a wave of change usually referred to as New Public Management swept over the public sector and a number of private sector management techniques were implemented, including the concept of performance management. The traditional concept of financial performance measurement clashed against the intricate notions of good care, subsequently leading to the introduction of new performance measurement tools that included non-financial performance measures. However, these tools were also adopted from the private sector and not tailored for the decentralized healthcare organizations with its many stakeholders and individuals of different professions.

The decentralized healthcare organization is subject to the control complexities of action at a distance, where operating personnel might have difficulties in interpreting, understanding or personally rationalize the inscriptions inherent in specific accounting techniques supporting certain programs or objectives. Within public mental healthcare, the issues of performance measurement are even further enhanced due to the absence of objective outcome indicators, making the different users' interpretations of performance measurement imperative to its result. Although there is substantial literature on the topic of management accounting within public healthcare in general and public mental healthcare in specific, there is a gap in the research of the interpretations and perceptions on account of the actors at different hierarchical levels within healthcare organizations regarding the purposes of given performance measures.

Hence, in order to aid the further development of performance measurement within public mental healthcare, this study focuses on the role assigned to given performance measures by personnel at different hierarchical levels within a public mental healthcare organization, the reasons therefore and the consequences thereof. A qualitative case study conducted within the region of Västra Götaland, Sweden, illuminates the meaning of hierarchical communication, role perceptions, sense-giving, accountability, stakeholder perspective, and cooperation in developing performance measures as shaping the perceptions of performance measures at different hierarchical levels.

Abbreviations

BUM = Beställar- utförarmodellen (the Purchaser- provider model)

BUP = Barn- och Ungdomspsykiatrin (Child and Adolescent Psychiatric care)

EBP = Evidence Based Practices

HSA = Hälso- och sjukvårdsavdelningen (support function linked to HSU)

HSN = Hälso- och sjukvårdsnämnden (Healthcare Committee)

HSNK = Hälso- och sjukvårdsnämndernas kansli (support function to HSN)

HSU = Hälso- och sjukvårdsutskottet (a committee that forms part of RS)

KS = Kungälv's sjukhus (Kungälv Hospital)

NPM = New Public Management

PC = Psychiatric Clinic

PM = Performance Measurement

PMs = Performance Measures

PRIO = Handlingsplan för psykisk ohälsa – Plan för Riktade Insatser inom området Psykisk Ohälsa, 2012–2016. (Action plan for targeted interventions in the area of mental illness, 2012-2016).

Qstar = Kvalitetstjärnan (the Quality star)

RF = Regionfullmäktige (the local Regional Council)

RK = Regionskansliet (support function to RF and RK)

RS = Regionstyrelsen (the local Regional Board)

SIP = Samordnad Individuell Plan (Coordinated Individual Plan)

S/P/M/HC = Swedish/Public/Mental/ Healthcare

SocS = Socialstyrelsen (the Swedish National Board of Health and Welfare)

SKL = Sveriges Kommuner och Landsting (The Swedish Association of Local Authorities and Regions)

SR BUP = Sektorsrådet BUP (the BUP Sector Counsel)

VGR = Västra Götalandsregionen (the Västra Götaland Region)

VÖK = Vårdöverenskommelse (Contractual agreement of Healthcare services formed between the purchaser and provider)

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1 Background

1.1 Introduction and Problem Statement

The demand for public healthcare services has increased rapidly during the previous fifty years. From 1960 until 1980 the resources allocated to healthcare rose from 4,7- to 9,4 percent of the Swedish GDP. In the 1980s the development slowed down but the increase of expenses for healthcare increased in proportion with the growth of the GDP. In the beginning of the 1990s, Sweden experienced the most severe economic crisis since the Great Depression, causing substantial public finance deficits and a rapidly growing national debt. As a result of the situation, comprehensive cut-downs were facilitated and increased the demand for cost control and efficiency while still maintaining a good service quality without putting a too large strain on the tax payers (Hallin & Siverbo, 2003; Brignal et al., 2000). However, three prominent features of the changing healthcare environment put additional pressure towards increasing the expenditures, including a demographic change of the population leading to an increased proportion of elder people, the recent development of medical and technological knowledge, and higher demands and expectations on the service provided due to the technological progresses (Elg et al, 2011; Hallin & Siverbo, 2003). Simultaneously, the financial resources are not expected to increase, which intensifies the need for additional solutions and to develop the healthcare and make it more efficient (Elg et al., 2011; Hallin & Siverbo, 2003).

One response to the changing healthcare environment and increased pressures was the implementation of various management techniques from the private sector, the process of which gained widespread attention in the OECD countries during the 1980s. This management wave is generally termed as New Public management (NPM) (Hood, 1995; Dunleavy & Hood, 1994). Accordingly, a dramatic change towards *accountingization* (Power & Laughlin, 1992), similar to the one within the private sector, was experienced within the public sector of the OECD countries (Hood, 1995).

Since the 1980's there has been an explosion in auditing within a broad array of different organizations. This has led to practitioners and policymakers becoming obsessed with regulation and measurements in a desire to quantify information (Power, 1997). This "Auditing revolution", as described by Power, can also be put into the perspective of the rise of Performance Measurement (PM), which has been subject to an intensified implementation by companies during the last decades (Neely, 1999). Neely dedicates this phenomenon to several factors, such as the change in competition due to the globalization; the cost structure being harder to define (sharp increase of the proportion of OHs/TC); new IT allowing for better data analysis; and an increased pressure from different stakeholders. All these aspects have led to an ever more complex business climate and a greater need of being able to evaluate how an organization is performing (Neely, 1999).

Apart from the fact that the number of PMs used within organizations has increased in general, there has also been a change in what kinds of PMs that are being measured. Historically, the focus has been upon the financial measurements of the company, but along with a greater complexity in defining the cause-effect relationships leading to specific monetary results, there has been a shift towards including a larger proportion of non-financial PMs (Neely, 1999). This is especially important when it comes to non-for-profit organizations since their main objective is not to achieve maximal economical

profit for the shareholders, but instead of providing some kind of public service, where the quality of the service cannot be measured accurately in financial terms (Merchant and Van der Stede, 2012).

As a response to these problems of measurability, many different forms of Performance measurements systems (PMS) have evolved, such as the Balanced Scorecard, Business process reengineering and TQM (Siverbo and Åkesson, 2009). However, these PMS have their origin in the private sector, which further complicates the implementation and has led to some criticisms regarding the implementation and use of these in non-for-profit organizations, such as in the case with the Swedish Public Healthcare (SPHC) service providers (Forsell, 1999; Paulsson, 1993).

The interpretation and use of PMs in the PHC is also problematic due to the fact that there are many different stakeholders with different goals within the context of the organization. This actualizes the question regarding accountability in terms of which individuals are accountable to whom, for what, how, by which procedures and by what standards (Emanuel and Emanuel, 1996). The operating personnel is constituted by professional, highly educated people that might strive to offer the best quality at hand at all times, and whom see the PMs as an unnecessary obstruction of their ability to provide the best possible service to the patients and something that stands in conflict with their ethical norms (Ouchi 1979). The government and the local county, may have a different view on what is important to focus on and the patients themselves may have yet another perception regarding which features are essential to them. Further, the decentralized organization is subject to the control complexities of *action at a distance*, where operating personnel might have difficulties in interpreting, understanding or personally rationalizing the inscriptions inherent in specific accounting techniques supporting certain programs or objectives (Robson 1994). The political programs and certain expertise of the management might not be in accordance with the knowledge and perceptions of the operating personnel, whom if not understanding or able to deem a change as necessary, might feel flooded or overwhelmed by the quantity of inscriptions. All in all this presents a difficult puzzle of multiple dimensions to be taken into account while measuring performance (Ballantine, Brignall and Modell, 1998). In short, the usage and interpretation of different PMs within the SPHC is a difficult task due to the complexity of measuring intangible aspects of quality and the divergence in perceptions of what is important between different internal and external constituents of the organization.

The attention to PM within mental health care has increased during the last years and it is now high on the agenda, yet health service organizations in general have had difficulties with the development of good performance measurement systems (Adair et al., 2003). However, within mental health care in specific, this process is further complicated by the fact that there is an absence of objective outcome indicators, such as could be found in somatic healthcare (Baars et al., 2010). Adair et al. (2003) conclude, "the concept of PM has no agreed upon definition in or across the literature". The definitions often include a number of purposes, such as Baars' et al. (2010) definition of PM as accountability, quality improvement and performance management, which at least points to the multifaceted nature of PM. Thus, although in some cases having been proven quite useful and effective, PM within mental health care faces substantial issues of defining, measuring and assessing these aspects (Epstein, 1995; Adair et al., 2003). As in the case of public mental healthcare (PMHC) in the VGR, the organizational structure is decentralized through the application of the *purchaser-provider model* (BUM), with a high degree of complexity that can give rise to different interpretations at different levels. If not able to overcome these issues, which indeed are present, the roles of the specific PMs applied in the control system will thus remain undefined. Further, if not

clearly defined, the PMs will not be able to either capture or communicate the reality from a distance, which serves as their purposes (Robson, 1994). And if neither capturing nor communicating the reality, what is the role of a certain PM?

1.2 Purpose

Although the topic of management accounting within the PHC sector is represented by substantial literature, a review of this research demonstrates a gap in the research of PMHC actors' individual perceptions of the rational for and effect of the usage of PM. Further, there is a striking absence of research investigating the role assigned to specific PMs by different users throughout the hierarchical chain of PHC organizations. Understanding these users' interpretations of certain PMs and the resulting consequences is a cornerstone in the understanding and development of PM within PMHC. Having established the presence of certain complexities regarding measuring performance and quality in PMHC, an investigation of how and why specific measures are perceived and understood in certain ways by the individuals throughout the different levels of a PMHC organization is the focus of this thesis. The analysis of the practical role of specific PMs within different hierarchical layers of a PMHC organization seeks to increase the understanding of the nature of PM within this context in order to serve as a theoretical brick in the further development of PM within this field. The study is thus based on the research question:

How is performance measurement being perceived at different hierarchical levels of a PMHC organization and what are the antecedents and consequences thereof?

2 Method

In this section the methodological concerns will be illuminated with the aim of clarifying the choice of research design made by the authors, hence also describing its features. In order to explain and rationalize the authors' considerations regarding methodology and research design, the significations of the chosen target of the study and research question must be described.

2.1 Classifying Research

Public sector accounting research (PSAR) has become a well-established research area with a varying use of quantitative and qualitative research methods. The US approach is mainly characterized by a positivistic methodology, focusing on quantitative research methods. Non-US research is on the other hand dominated by interpretive and critical approaches, relying on qualitative methods (Goddard, 2010). The variations and combinations of approaches to the research topic present a crossroad with several potentially adequate routes.

The terms *quantitative* and *qualitative* research can, according to Bryman & Bell (2007), "be taken to form two distinctive clusters" of the *research strategy*, where the choice of either is defined by the authors as the general orientation to the conduct of business research. In general terms, quantitative research is interpreted as a research strategy focusing on quantification in the collection and analysis of data, entailing a deductive approach accenting the testing of theories. In contrast, qualitative research stress words instead of quantification in the process of collection and analysis of data and is in turn emphasizing an inductive approach, focusing on the generation of theories.

The chosen qualitative methodology of the research is a case study (Collis & Hussey, 1997; Eisenhardt, 1989). The study is of a profoundly qualitative nature, conducted within the research paradigm of interpretivism, which in turn is based on the belief that social reality is colored by our perceptions and therefore highly subjective. The advocates of interpretivism consider people to be palpably intertwined with the social contexts in which they exist and hence, people and contexts are not separable from each other. If maintaining this viewpoint, it is thus impossible to understand people without scrutinizing their perceptions of their own activities. In order to identify patterns in the social behavior and perceptions of people within social contexts, more than one type of research method is often employed (Collis & Hussey, 1997; Bryman & Bell; 2007).

Whereas these decisions could be classified as choosing the process of the research, there are indeed a number of additional aspects to bear in mind as well. These could be denoted as the research's purpose, outcome and logic (Collis & Hussey, 1997). The purpose of this study is of a descriptive and interpretative nature, aiming to investigate the subject in order to describe certain phenomena and ascertaining germane issues (ibid.). However, being of a somewhat practical nature, the intended outcome of the study mainly takes the form of basic research. Thusly, it focuses less on direct problem solving and more on adding to the theoretical body of knowledge regarding PM within PMHC in specific and PHC in general in order to assist in future solutions. This is supported by the fact that the intended study relates to issues that are of complex social nature where strikingly practical solutions are unlikely to be found (ibid.). The logic of the study is abductive, moving both from general to the specific and vice versa.

Representing the move from specific to general is the inductive approach, inducing general conclusions from particular instances and developing theory from the observation of empirical actuality. The antagonist is the deductive approach, deducing hypotheses based on what is known about a certain area and the theoretical considerations relating to this area, in order to subsequently test it by empirical observations (ibid.).

2.2 Research Design

The quality of any research is dependent on its design, which is the guide to the selection of sources and information, creating a framework that specifies the relationships between the study's variables and the fashion in which different activities are conducted (Blumberg et al., 2008). The design of this study can be denominated as an iterative process, between the theoretical body and the empirical findings, taking off from an extensive literature review. Below, a presentation of the chosen structure, approaches and processes of the research will follow.

An abductive method was used in reasoning between phenomena and their theoretical explanations. The approach to the literature was of a deductive nature, comparing the explanatory goodness of the theories in order to construct the theoretical model. On the other hand, the approach to the gathering of empirical data was inductive, assessing empirical phenomena from the perspective of the theoretical model in order to propose general conclusions.

In order to develop an effective approach to the research process, a comprehensive theoretical orientation was acquired together with a conceptualization, thus creating an orienting set of explanatory concepts in order to aid the empirical investigation (Ahrens & Chapman, 2006). Here, it is necessary to consider the balance between adapting an overly theoretical approach, which can have little practical value, and the opposite approach, which can yield too general and uninformative conclusions (Vaivio, 2008). The process of developing the conceptual framework consisted of a thorough investigation of research where empirical evidence of performance measures and measurement being perceived ambiguously within organizations were found and explained. The particular findings were subsequently brought together, constructing a general theory to support the descriptive research. The purpose is therefore to investigate and describe this phenomenon by using the theoretical body as a foundation, assisting the empirical gathering and analyzing (Vaivio, 2008).

2.3 A Qualitative Case Study

Public sector accounting research is associated with varying methodological approaches, adapting both positivistic and interpretive research methods (Goddard, 2010). The existence of the mostly European tradition of using qualitative approaches to management accounting research is sometimes viewed as providing a necessary counterweight to the theoretical influence of North America, maintaining theoretical and methodological pluralism (e.g. Vaivio, 2008). However, according to Collis & Hussey (1997), there is a greater need to explain the rationale for using interpretive approaches than for positivistic approaches, which might be rationalized on the basis of the positivistic approach as being inherent in the nature of the quantitative method, which traditionally have been the dominating one (Collis & Hussey, 1997; Bryman & Bell, 2007; Bryman, 1984).

The case study examines the topical phenomenon in the detailed context within which it appears, focusing on understanding the dynamics present within single settings (Eisenhardt, 1989). It is studied against a rich background of the organizational processes' differing sectional interests and strains, which are shown in the calculations and practices of management accounting. Combined with the understanding of the context, the different observations within the case offer an opportunity to the researcher to appreciate the social dynamics surrounding the topical phenomenon. The result is a plausible and contextually rich explanation of the studied phenomenon that renders theoretical value (Vaivio, 2008). Essentially, the underlying explanation for the choice of conducting a qualitative case study when approaching the topical phenomena of this thesis adheres to potential "blindness" that can accompany positivistic research. This blindness can appear when not accounting for the, possibly, underlying social reality's subjective and constructed properties, which are central to the topical research question (Ahrens & Chapman, 2006).

Qualitative methodology can contribute to research by "helping us understand the how and why of management accounting practice" (Bogt & van Helden, 2012). Vaivio (2008) describes the benefit of using qualitative research as taking us "beyond a narrow and functionalist view of the management accounting phenomenon". Further, he refers to qualitative research as protecting us against the dominating, classical economics view that he concludes to reduce management accounting to simply being an issue of economic choice. However, some critics of qualitative research argue that it has an inability to maintain objectivity, entail practical relevance and to generate generalizable theory (Bryman, 1984; Bogt & van Helden, 2012; Vaivio, 2008). In contrast, proponents stress that qualitative research's purpose is neither to maintain the objectivity that is so profoundly valued in the practices of its counterpart, nor to generalize eternal truths. Instead, in order to understand the phenomena of management accounting, there is a need for more than a general theory. By closely investigating certain contexts in a fashion unlike the eagerly objective quantitative research, this understanding can be shaped by qualitative studies, which indeed also display regularity and predictability beyond the context of the case in a practical sense (Vaivio, 2008). Nevertheless, in our strive for this study to generate theory for other researchers, efforts were made to keep a distance and to maintain an objective lens through which all empirical data was viewed.

Finally, Ahrens & Chapman (2006) conclude a qualitative study undertaken in the field to be not simply empirical, but a profoundly theoretical activity. However, according to Vaivio (2008), it is imperative that the researcher undertakes an empirical sensitivity and is not bound strictly by the theoretical focus developed for the analysis of the empirical data. Otherwise the researcher might fail to grasp essential empirical insights that fall outside the theoretical perspectives that are serving as a foundation for the research. He notes, in addition, that when conducting a case study, which is typically undertaken during a shorter period of time than a field study, it is imperative that the researcher is aware of the shorter timespan as somewhat endangering the reliability and validity of the studied context.

2.4 Scope and Scale of the Case Study

The study was conducted in the region of Västra Götaland, Sweden. The research investigates the perceptions of different hierarchical levels of a healthcare organization therein. The hierarchical levels included in the study ranges from two provider levels at Kungälv's Hospital (KS), to two purchaser levels that order the care packages specifying the performance targets for KS. The provider and purchaser levels consist of a child and

adolescent psychiatry unit (BUP), the psychiatric clinic (PC) of KS, Hälso- och Sjukvårdsavdelningen (HSA), and Hälso- och Sjukvårdsnämndernas kansli (HSNK). The scale of the hierarchical structure has been selected to be able to present a spectrum from the purchaser level of the VGR, through the top management of the psychiatric clinic at KS, down to the operational level of the outpatient care regarding a specific BUP unit. The different levels are further described in part 4:1-2.

In order to examine how different PMs are being perceived at different levels of the PMHC organization, a scope consisting of two PMs was chosen: The “Productivity Measure” and the SIP. The productivity measure assesses productivity in terms of patient visits per doctor, and the SIP assesses certain qualitative aspects. This scope was chosen in order to include, for the study, relevant subjects of measuring performance. The PMs were selected due to their significance as being central in the work of BUP at KS, based on information deduced from the first interview made at the PC of KS and a subsequent scrutiny of the available secondary data on the subject. These different PMs are presented in more detail in part 4:3.

2.5 Delimitations of the Case Study

The selected scale of the study leads to that additional aspects, which can have an effect of the perceived purpose and usage of different PMs, are being excluded from the research. This has been an active decision by the authors in order to be able to focus the study on the professional hierarchical structure and refrain from arriving at an overly broad scale. Due to the interrelatedness some mentions had to be made regarding the political levels influence, etc., but these aspects are not the focus of the study. What is being researched and analyzed is the relationship and differing perceptions between the purchaser and different hierarchical segments of the provider level.

The selected scope only represents a small part of all the different PMs that are being used within the different levels. The focus is directed towards a certain PM included in the contractual agreement (VÖK) between the purchaser and provider and one PM that is part of the national funds being distributed through the VGR. The exclusion of other PMs have been necessary to better be able to understand the implications of the ones that *have* been selected and the authors view the included PMs as being representative for the purpose of the research.

2.6 Data Collection Method

Mainly, the empirical data consist of primary data collected through qualitative methods in terms of interviews. In addition, secondary data was acquired through reviews of official reports and documents relating to performance measurement within public health care, enabling a process of increasing the reliability of the research through triangulation between different empirical materials (Vaivio, 2008; Eisenhardt, 1989). These reports and documents are reflecting both PHC in Sweden in general as well as within VGR and PMHC in specific. Since most reports and documents within the PHC in Sweden are public, the secondary data was collected both with the guidance of the interviewees and independently by the researchers. The investigation of the gathered material was conducted with an inductive approach. The interviews were conducted in an open nature and the specific responses presented by the respondents induced general propositions, which in addition subsequently were tried against the theoretical context. The inductive approach chosen for theorizing around the empirical data is motivated by its allowance to trial of several theories against the specific case of PM

within PMHC and because of its non-confirmation seeking, which is important in order to describe the full picture (Collis & Hussey, 1997; Haig, 2005). However, it is important to bear in mind that critics have questioned the inductive approach's excessive trust in the power of observation, although proponents stress its importance for fashioning empirical generalizations (Haig, 2005).

2.7 Interviews

In contrast to using, for example, talking-questionnaires, one central benefit of using qualitative interviews is that the questions are rather loosely structured and provides the possibility for the interviewee to choose what things are relevant and important to talk about, given the interest of the research project. A rich account of the interviewee's experiences, knowledge and impressions can thus be considered and documented. However, it is further important to bear in mind the linguistic issues of conducting an interview, not merely considering the answers as a moral truth in the name of science (Alvesson, 2003). Thusly, the interviews were not only viewed from the eagerly exploratory lenses of finding new insights, but also carefully observed from the perspective of the theoretical framework with an awareness of the circumstances influencing the interviewees' thoughts and perceptions.

The interviews form the foundation of the empirical gathering and thus, analysis. In-depth, semi-structured interviews were conducted at four different levels of the hierarchical system of PHC within VGR, ranging from the providers to the purchasers of PHC. In addition, supplementary questions were e-mailed to complement the answers regarding some aspects. The choice of method for gathering empirical data was made in line with the advocates of using qualitative interviews, seeking to facilitate open discussions and conversations with the interviewees in order to provide a neutral situation where their own perceptions of the aspects relating to the topical questions could be expressed. The structure of questioning and the opening questions facilitating the conversations (see appendix: 1) were developed in accordance with the theoretical framework, the purpose of which was to introduce the interviewees to our intended areas of investigation and subsequently allow them to guide us through their perceptions without being constrained by our theoretical lenses. The language used was neutralized away from typical management accounting jargon, but not fully towards healthcare terminology, in order to create an environment within which both the interviewers and interviewees could speak the same language.

Contact was established with the Chief of Operations at PC of KS via e-mail, explaining the intended and independent focus, scope and scale of the study. No specific questions, besides the presentation of the overarching research question, were provided in order to enable such an informal and genuine conversation as possible when conducting the interview. However, although the nature of the interviews was informal and open, the interviews were thoroughly prepared and shaped in order not to generate respondent bias. The COO subsequently aided us in contacting an operational manager at a subdivision and a development leader operating as a link between purchaser and performer, whom in turn gave us references to an interview subject at the purchaser level. These additional interviewees were provided with the same presentation of the intended study and were not introduced to any specific interview questions in advance. The interviews were then conducted in Swedish between February and April of 2014. All interviews were recorded with the approval of the interviewees and all but one of the respondents waived the right to be anonymized. The interviews and answers to the supplementary questions were subsequently translated into English. The completed compilations of gathered empirical data from each interview were then sent to the

respondents respectively in an attempt to further minimize any potential misrepresentation of their views. All but one responded. The responses received were approving of the compilations as being a true and fair representation of their views, in some cases adding minor requests to deduct or highlight something, which was then coherently performed.

2.8 Secondary Data

In addition to the interviews as the main sources of empirical data, secondary data was collected to aid the empirical analysis. Since essentially all secondary data relating to the topical research question is public material, no particular access or allowance was needed. Instead, interviewees provided us with material they deemed as useful for the empirical analysis and additional information was acquired from national and municipality websites, along with annual reports and other supplementary documents through an extensive scrutiny of data relating to the topical questions from various national and local sources.

The initial use of this data was in order to understand the structure and function of the PHC within VGR and in order to gain a general understanding of its management accounting systems. As the research proceeded, the originally collected data used together with additional secondary data collections and investigations in order to aid the analysis of the research question. In this case, a potential limitation of the usefulness of the secondary data stems from the open environment within which it exists. In contrast to a private business intranet, which stores information at approximately the same location, these public documents are to be found at numerous websites and in various publications, making the possibility of missing certain data more likely. However, the various sources referred to by the different interviewees along with the substantial, independent secondary data collection constructed a broad basis, less likely of facilitating biased conclusions.

2.9 Analysis of Data

According to Ritchie & Lewis (2003), in contrast to the quantitative analysis, the qualitative analysis entails no clearly agreed upon rules or procedures for analyzing data. Management accounting tends to be complexly interwoven in the untangling of certain events as both causes and effects of changes. It is not easily classified as merely a dependent or independent variable. One alteration can lead to profound changes in an organization and entail subsequent changes in accounting (Ahrens & Chapman, 2006; Hopwood, 1987). In order to subsequently aid the analysis of the gathered data in this complex environment, a theoretical framework was developed in advance to create an empirical grounding for possible emergent theory, nonetheless with the awareness that the chosen theories might not be all-encompassing and have certain limitations and biases (Eisenhardt, 1989).

Investigating the differences and similarities between the perceptions of employees at different hierarchical levels within a PHC organization, the interviewees were chosen because of their relatively polar positions, which made the observation of the topical processes of interest more easily observable (Eisenhardt, 1989). In addition, public documents and reports referring to the same issues were gathered and analyzed in comparison with the empirical findings from the interviews. When conducting the interviews and reviewing secondary data, a comprehensive effort to code certain types of data and to overlap the data collection with the data analysis by writing commentary

notes during the data gathering was made (Ritchie & Lewis, 2003; Eisenhardt, 1989). This provided flexibility in the data collection process, where need for gathering additional data relating to certain cases could be identified at an early stage.

When conducting a case study, analyzing data forms the main fountain for building theory, but also the most difficult and least codified part of the theory building process (Eisenhardt, 1989). It is a continuous and iterative process (Ritchie & Lewis, 2003). Each case was summarized after gathering data and subsequently categorized according to key themes (Ritchie & Lewis, 2003; Eisenhardt, 1989). Then, a cross-case search for patterns was conducted with an emphasis on scrutinizing the data from several viewpoints and in different ways in order to avoid jumping to false conclusions (Eisenhardt, 1989). After having identified similarities and differences between the respondents' perceptions, a comparison between the emerging concepts and the theoretical framework was made, seeking to evaluate the similar or contradicting relationships and the reasons thereof.

2.10 Generalization, Reliability and Validity

The assessment of the relevance of the study beyond its own bounded context is a profoundly central issue when evaluating the research. However, there is no consensus among authors as to whether it is possible to support wider inference by qualitative research findings. This assessment regards both the empirical applicability to populations or settings beyond the one topical for the study, as well as theory building in terms of generality (Ritchie & Lewis, 2003). There exists no generally accepted set of criteria for assessing the theory building using case studies and the distinctions between empirical and theoretical generalization are not applied in a single, generally accepted way (Eisenhardt, 1989; Ritchie & Lewis, 2003). However, according to Ritchie and Lewis (2003) it is possible that generalizations can be drawn from qualitative data, in relation to the topical population containing the sample, about other settings under similar conditions, and as a contribution in terms of generating or developing theory.

In order to infer wider meaning to the theory building, a number of key principles have to be assessed. Hence, drawing on Eisenhardt (1989) and Ritchie & Lewis (2003), the authors strived to make full use of the original data, providing as rich evidence as possible when classifying and interpreting the data. Further, a strong emphasis was placed on viewing and depicting the investigated phenomena from various perspectives, following a careful analytical procedure. In addition, efforts were made to display the meanings and interpretations assigned to the empirical data in order to provide a transparent account of the underlying aspects making up for the conclusions.

The terms reliability and validity stems from the natural sciences, leaving certain concerns regarding the applicability on qualitative research (Ritchie & Lewis, 2003). Reliability concerns the replicability of the research findings if tried in another case under similar conditions with similar methods. Here, issues arise regarding the complexity of the phenomena being studied in the qualitative research, which is likely to be closely intertwined with the case-specific context, making the original concept of replicability somewhat inapplicable. With this in mind, the focus here is diverted towards terms of trustworthiness, where aspects such as the likeliness of a recurrence of the data and its interpretation, both in terms of internal and external reliability (Ritchie & Lewis, 2003; Eisenhardt 1989). The authors recognize the unlikeliness of direct replication to take place if similar studies were undertaken, given the ever-changing nature of the topical context and the subjective perceptions of the respondents; however, simultaneously stressing that the transparent structure of the

research provides a reasonable idea of the potential findings on the subject in this given context if a similar study was to be conducted.

The validity can be understood as the correctness or precision that a research reading provides. The internal validity regards whether the authors are actually investigating what they claim is being investigated, whereas external validity regards the possibility of generalizing the conclusions drawn from the data and hence if the given sample also can be said to represent other contexts (Ritchie & Lewis, 2003). Nevertheless, it is a mistake to seek to produce such a statistical generalization in the single case study, as is this thesis. Instead, the external validity can be sought in terms of theoretical generalizations that test theory against the empirical reality of certain contexts, and in addition by building hypotheses for subsequent research to test at a more general scale (Vaivio, 2008). Although underlining the somewhat misleading associations this use of terminology entails, triangulation processes of combining different methods and sources for gathering data, as well as a process of looking at data from different theoretical perspectives, were undertaken in order to increase the validity and by creating rich accounts of and explanations for the perceptions and relationships within the studied case (Ritchie & Lewis, 2003; Vaivio, 2008; Ahrens & Chapman, 2006).

3 Theoretical Framework - Measuring performance in PMHC

To be able to better comprehend the specific context of the research, a presentation of relevant theories will follow in this section. As mentioned in the introduction, measuring performance can be a complex task in the PMHC. The following theoretical framework therefore aims to clarify some of the aspects that can have an impact on the perception of PM for different hierarchical levels in a healthcare organization. The first part consists of a classification, presenting a view of the context to which the PHC can be described as pertaining. The second part portrays how productivity and quality can be assessed within PHC and how these are linked to the resources, processes and outcomes of the health care service. Lastly, the third part intends to illuminate some factors that have an impact on the perception of the purpose and usage of different PMs seen from different hierarchical perspectives.

3.1 Classification of PHC

In order to discuss specific ways of measuring performance in PMHC, an outline of the context and different characteristics of what constitutes a HC organization will be presented, describing different aspects regarding PM within such an organization.

According to Fottler (1987), defining and measuring output in HC is difficult due to the complex and variable work of specialized and highly independent professional groups. In many HC organizations there exist problems of coordination and accountability stemming from the role ambiguity and role conflict that occur when clinical staff is faced with result controls whilst simultaneously remaining true to their strong work ethics (ibid.). The complexity regarding PM in PHC is further enhanced by the complicated structures of the financial, political and legal environments, leading to an increased importance of how to communicate the information both internally and externally to different stakeholders (ibid.). To further describe some general principals of a Swedish PHC organization, three main characteristics will be outlined in accordance with the studies of Docent G. Paulsson (1993).

First, the Swedish PHC can be seen as a *non-for profit organization*, leading to the absence of one of the most common aspects regarding PM: profit. This lack of a strong indicator for assessing performance makes it difficult to identify a single indicator for measuring the outcome of the chosen actions (Anthony and Young, 1984). The goal of Swedish PHC is instead based upon the more vague definition provided by the Health and Medical Services Act as: "Health and medical services are aimed at assuring the entire population of good health and of care on equal terms." (Paulsson, 1993).

Second, SPHC can be seen as a *professional organization* within which the members of the profession have received authority over its clients from the community to provide healthcare services (Greenwood, 1957). Being a professional organization, management control of these professionals is associated with a number of issues. Since the work performed by these experts is highly complex, they have traditionally benefited from a high degree of autonomy. Their performance can thus only be adequately measured and controlled by other professionals with the same base of knowledge (Paulsson, 1993). The professionals of such an organization strive towards decentralization and the keeping of administrative influence to a minimum in order to maintain a large amount of autonomy over the operations (Mintzberg, 1980). Due to this, the operative staffs of

these organizations are also more prone to resist an increased use of management control, since their autonomy may be threatened by increased administrative systems (Paulsson, 1993). This can be seen in the light of the recent development, with an intensified use of PM within the PMHC and the ongoing debates regarding the implications for the clinical staff in Sweden during the last years.

Thirdly, a SPHC organization can be seen as a *producer of services*, where the output is made up of healthcare. The intangible services are hard to define in exact outcomes and the consumption is strongly intertwined with the production of the services. Since they demand the presence of the patients, controlling the production becomes much harder and the intangibility of the output is hard to measure, leading to aspects as quality becoming something subjective (Paulsson, 1993).

These 3 main characteristics all implies that PM in PHC is a complex task due to many different factors: the lack of the possibility to measure profit demands for other output measures; the clinical staffs' demand for autonomy and resistance against decoupled administrative control; and the intangibility of the intertwined services, posing difficulties for the production and measurement of output and quality.

3.2 Complexity of Performance Measurement in PMHC

The following section will give a brief outline of how PM regarding productivity and quality is being conducted in the PHC in general, complemented with examples stemming from the PMHC. Thusly, it forms a base intended to support a more comprehensive understanding of productivity- and qualitative characteristics pertaining to the two focal PMs.

3.2.1 Productivity and Efficiency

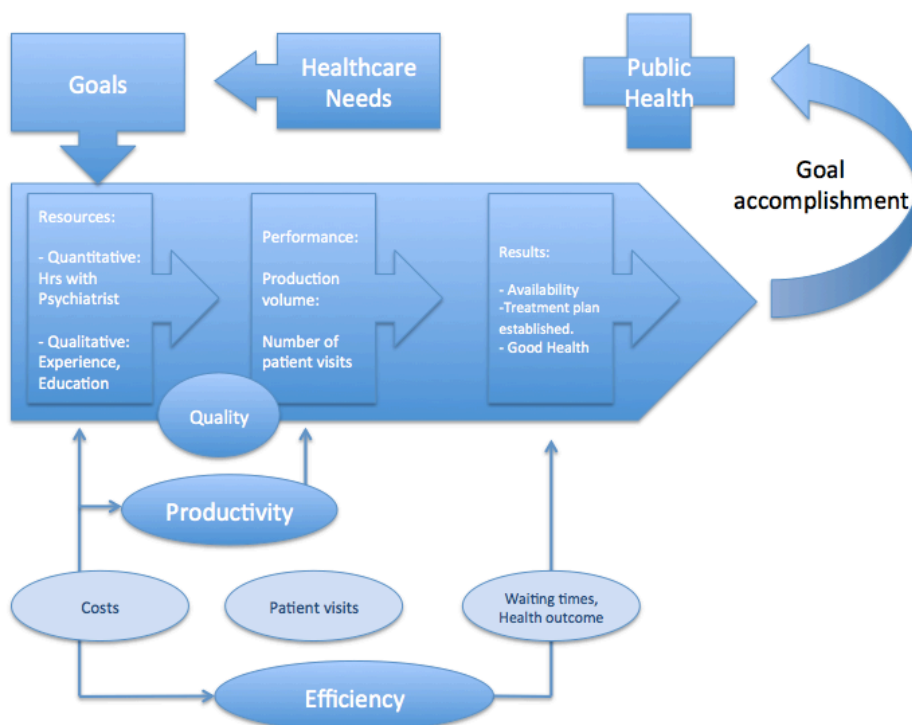
Productivity is defined generally as a measure to describe the amount of output generated per unit of input; the ratio of what is produced and the amount that is required to produce that amount (Linna, 2009; Slack, 1999). When measuring productivity it is important to recognize that there are many different kinds of input that transforms into the output of the measured operation, translating into many different ways of measuring (Johnston and Jones, 2003). At one side of the scale is the most simplified version: to look at the ratio between one isolated aspect of input and compare this with the total output (Slack, 1999). A major problem with analyzing this kind of single factor productivity is that all increases in efficiency may be attributed to the sole factor being measured, regardless of whether the change has been due to other factors instead (Linna, 2009). At the other side of the scale is total factor productivity, which instead takes into account all different constituents of inputs (total input) and compares these with the total output. The latter can be regarded as a more complete and thus better way of calculating the cost of productivity, but it is also much more difficult due to the complexity of determining the different factors involved and their contribution to the final output (Slack, 1999). A natural tendency might therefore be to pick a measure based on how convenient it is to measure, although it may not be as important as other measures (ibid.).

The definition of inputs and outputs is the most central aspect when measuring productivity (McLaughlin and Coffey, 1990). Traditionally, quantitative physical units have been used for this purpose; input may then be explained in hours of work and outcome in number of patients received. However, if productivity is only improved in a

quantitative sense, this might have a negative effect in terms of a greater share of low quality performance (Linna, 2009). Hence, previous research has pointed out the need to include aspects of quality to better be able to interpret the results of productivity and efficiency of services in the PHC (Edström et al, 2008; Johnston and Jones, 2003; Lind, 2013).

Regarding the SPHC, the Swedish Association of Local Authorities and Regions (SKL) has made a distinction between effectiveness, efficiency and productivity of HC services as follows: *Effectiveness* is the degree of which results have been achieved in comparison with *available* resources. The main goal being: “good health for the whole community” and the resources being all different components used in PHC, both quantitative and qualitative, such as: doctors, equipment, medicine, etc. (Ackerby, 2008). *Efficiency* is instead related to the degree of accomplishment in achieving healthcare *results* compared to the *utilized* resources (ibid.). Lastly, *Productivity* is seen as the relationship between the used resources and the amount of *performance output* (healthcare services) that is the product of these efforts, e.g. measuring performance in terms of patient visits and comparing this to the cost of producing them (ibid.). However, Ackerby (2008) also underlines the importance of recognizing the lack of completeness in measuring productivity in terms of efficiency. More is not always better, since a higher amount of performance in e.g. the amount of patient visits per doctor, could lead to a decreased quality of the care. A patient visit can be of a more or less complicated nature, since all patients have different needs. Therefore qualitative aspects should also be considered when analyzing the results. However, this is, as previously mentioned, more complicated to measure and the current usage of PMs often do not allow for such qualitative adjustments (ibid.).

The figure below presents the view of the relationship between productivity and efficiency from SKL’s perspective; effectiveness is being represented by the goal accomplishment as the sum of all activities.



Source: The authors’ own interpretation based upon the models of Ackerby (2008) and Socialstyrelsen (2013).

It is important to stress that this way of looking at efficiency, productivity and qualitative aspects is seen from the healthcare givers perspective. In the totality of performing healthcare services within the PHC, and increasingly so regarding the PMHC of BUP, many different principals need to coordinate their actions in order to achieve an efficient result (Blomqvist, 2012). This can be seen from a societal economical point of view where the performance, although being efficient, with high productivity at the individual care giver (local BUP clinic), may not be efficient from a larger perspective e.g. if the results where to originate from a low resource utilization that has as a direct consequence that other parts of the society have to put in more resources to compensate for this (Socialstyrelsen, 2013). The treatment of the BUP patients is closely intertwined with other functions of the public society such as social services, schools, day care centers, etc. (ibid.) The successful cooperation between these functions and principals is therefore important. This also implies that measuring and evaluating performance within this particular area becomes increasingly complex, since the performance of the individual caregiver becomes harder to separate from the other public functions (Moran, O'Connor and Borrowitz, 2013).

Overall, the various PMs that are utilized in the PHC only reflect a small amount of all the different activities that are being performed. Furthermore, the PMs used within PMHC are usually less developed in comparison to other areas of somatic PHC (Ackerby, 2008; Baars et al., 2010). As an example: symptoms and illness can often be complex and may include multiple diagnoses leading to that defining and measuring the results of the treatment is difficult (Holloway, 2002; Moran et al., 2013), in turn implying increased difficulties to determine factors of productivity and efficiency in this area.

3.2.2 Quality

As previously mentioned, measuring qualitative aspects in healthcare is complex and the task becomes increasingly difficult regarding the measurement of performance and outcome in PMHC, especially so in the case of BUP. It is important to recognize that it is hard to find a universal approach to assessing quality since the patients involved in the process are different individuals with varying needs and responsiveness to different kinds of treatments (Moran, et al., 2013; Norcross and Wampold, 2011). It is therefore also difficult to define a one, single criterion of measuring quality. Hence, an approach containing multiple indicators including various aspects is a common method to counter this problem (Donabedian, 2005). One frequently applied way of measuring qualitative aspects in PHC is to use *the Donabedian model*, developed in 1966 by Avedis Donabedian (1919-2000) (Lazar et al., 2013). This way of defining and looking at different aspects is one of the ways that SocS in Sweden has chosen to interpret the measurability of quality in PHC (Socialstyrelsen, 2013). According to Donabedian (2005), Quality can be seen as belonging to three different categories: Outcome, Process and Structure.

3.2.2.1 Outcome

Outcome is perhaps the most common aspect as it is the ultimate goal of the healthcare service: obtaining a good final result. For example, in the context of PMHC, a patient's social restoration after treatment can be seen as one indicator of how good the quality of the care has been (Donabedian, 2005). However, solely focusing on the outcome is not enough to be able to draw any viable conclusions of the quality of care. Many other aspects might have influenced the recuperation (or decline) of the patient's mental

health, which might be outside of the caregiver's control (Donabedian, 2005). Another aspect is time. This is especially important when it comes to the treatment of the patients of BUP, since the outcomes of the treatment for these young patients might first appear years later (Socialstyrelsen, 2013). Finally, although possible to define what would constitute a desirable outcome, it is hard to actually measure this in the PMHC since many of the aspects cannot be seen from the outside i.e. there are many intangible and subjective aspects, such as the patients' own assessment of how good he or she feels internally, etc. (Bickman and Salzer, 1997).

3.2.2.2 Process

Due to these difficulties in assessing quality by solely focusing on the outcome, another approach is to look at the *process* leading to the outcome. This can be achieved by assessing the means and methods used in the treatment of the patient to see if these can be considered as "good" from a medical point of view, based on the latest research and findings. The belief is thus that by achieving a good quality of the process, this will in turn lead to a qualitative outcome (Donabedian, 2005).

One way of controlling the process aspect of the quality of care is to use Evidence Based Practices (EBP). EBP can be described as the usage of the current best known practices in making decisions about the individual patients care, through a combination of the individual expertise and systematically assessed external clinical evidence (Sacket et al., 1996). EBP has become an important part of how to control the care giving process of the Swedish PMHC (Socialstyrelsen, 2009; Blomqvist, 2012). The use of EBP can thus be seen as a strive towards achieving a better quality of the process.

The complexity in identifying a specific "good practice" of giving care in a certain process can be defined as having a relatively high or low level of task uncertainty. All encounters with a patient involves medical problem solving that can be seen as having various degrees of task uncertainty related to how to define a problem, the value of a solution and the final outcome (Holmberg, 2006). The task uncertainty can be described as the difference between the information possessed by the care giving decision maker and the information required to perform a task to achieve the desired result (ibid.). The extent of how a treatment has been shown to lead to a specific sought after result for one group of patients can lead to a lower degree of uncertainty in the decision making for how to treat other patients (Regan et al., 2013). In cases with a low task uncertainty, finding ways to streamline the production could be very beneficial since it leads to a more efficient way of utilizing resources (Holmberg, 2006). However, it can be detrimental for the quality of care if such routinization is sought after when it comes to processes with a high level of task uncertainty, which is often the case regarding the PMHC (Franks, 2004), leading to an increase in the reoccurrence of visits (Holmberg, 2006). In order to avoid such routinized ways of handling processes with high task uncertainty Holmberg (2006) argues that it is important to see these in different structures and to evaluate them according to different standards. Performance of such processes with high task uncertainty should therefore not be evaluated in terms of productivity or other quantifiable measures (ibid.).

3.2.2.3 Structure

The final of the three categories in the Donabedian Model is structure. Structure can be defined as the setting where the processes take place, i.e. all the resources that are required to produce the services. Examples of these can be the facilities, the equipment and the expertise and knowledge of the staff (Donabedian, 2005; Messer and Wampold, 2002). Structure can be seen as the medium through which treatment is delivered. The general assumption made by Donabedian (2005) is that the components of the structure can decrease or increase the probability of achieving a good quality care, since they have an impact on the quality of the process and the final outcome. As such, outcome should not even be considered as a component of quality itself, but rather as a consequence of the treatment, which has its foundation in the structure (Campbell, Roland, and Buetow, 2000).

3.2.2.4 Combining the Three Categories

Donabedian's way of assessing quality is to be seen as a combination of these three different categories: Structure, process and outcome. When seen as isolated indicators it can be harder to assess the quality due to the inherent complexity in separating the components that all constitute characteristics leading to the quality of care. Thus, in order to determine whether the quality is good it is important to look at the aggregated picture of all different constituents. In this way the evaluation of the quality of care can be made more feasible as the negative implications of seeing them as separate entities may be reduced through the aggregation of all three aspects into a wider scope (Donabedian, 2005).

A similar approach to assessing quality through the utilization of a scope of measures including both Process and Outcome PMs can be seen in the tool Qstar used in the PMHC of Sweden. Qstar is being used for the treatment of some mental health patients diagnosed with psychoses, to determine the quality of the given care and to enable a better follow up procedure of the patients. This is achieved by looking at categories of different process- and outcome measurements that are based upon the assessment from the caregiver's perspective as well as the perceptions of the patient and the patient's relatives (NKR14-142). Although not including any typical measurement of structure per se, the structural perspective can still be seen as being present due to the inclusion of information in the tool regarding which doctors and other staff members have been involved in treating the patient. In this way Qstar can be seen as an example of a tool used in the SPMHC that is based upon principles adhering to the Donabedian model, since it combines several different categories of PMs in order to assess the quality of care.

3.2.3 Incomplete Indicators

Several different aspects regarding PM of productivity, efficiency and quality in PMHC influence the perception of the different measures. Due to the close linkage between different aspects, isolating different measures and looking at them individually might lead to an incomplete picture in terms of the ability to assess the quality (Donabedian, 2005). To measure quality, an approach using different aspects could be used in order to

obtain a broader representation of a combined view of the perceived quality (Donabedian, 2005, Socialstyrelsen, 2013). This way of viewing isolated qualitative aspects as more or less incomplete is also of importance when looking at other indicators regarding productivity and efficiency. Measuring productivity using a few simplified indicators is difficult and it can give a false impression if seen as isolated from efficiency and effectiveness (Linna, 2009; Ackerby, 2008). In order to account for the complex structures and processes that are parts of the inputs and outcomes of the services, more qualitative aspects of productivity should be considered as well (Edström et al., 2008).

However, since it is difficult to achieve this completeness through combining many different aspects and indicators and due to the push towards a more routinized and streamlined production thinking, the choice to use more simplified ways of measuring productivity and quality is often opted for, leading to the usage of many incomplete indicators (Edström et al., 2008; Linna, 2009; Slack, 1999; Franks, 2004; Holmberg, 2006).

3.3 Attitudes towards performance measurement

In the previous part, a brief presentation was given on the complexity and difficulties to define and assess productivity and quality within PMHC, especially regarding the treatment of children and adolescents where the increased need of cooperation amongst different principals further complicates these issues. In the following part, factors that can further influence how people at different levels of an organization perceive PMs differently will be discussed. Aspects such as how the accounting information is being distributed and made available, how the various stakeholders are putting pressure on the lower hierarchical levels of the organization, and how complex factors are simplified into quantitative measures – all can have an implication on the perception and usage of PMs at different hierarchical levels and the role of accountability therein.

3.3.1 Distribution of information

The substantial change that has taken place in the health care sector has entailed an emphasis on accounting and accounting visibility. Instead of being an outside threat, accounting is now a central part of the operations and administration (Jacobs et al, 2004). Certain problems have followed in the wake of the stress on accounting in public administration, in terms of too many measures and measurers as well as difficulties in designing information systems with sufficient quality, comprehensibility and magnitude (Eddy, 1998). This can also be seen in the Swedish PHC where the increased focus on PM has been perceived as complicated by many users and imposed a fear of that the administrative tasks will take up a too large proportion of both time and resources from the actual caregiving (Edström et al., 2008).

The organizations within healthcare, such as hospitals, are complex organizations. They often contain two divided elements in form of the medical staff and the administrative functions, which are seldom tightly linked. Within NPM, which is considered to stress private sector styles on public management (Hood, 1995), the assumption of economic rationality is based on the central theme of availability of information (Jacobs et al, 2004). Information regarding for example performance and targets are thought to exist and to be provided to the right people. An effective organizational information system assisting key decision-makers with financial and performance information is essential to

the operations (Hood, 1991; 1995). Traditionally within healthcare, doctors and to some extent nurses are considered to be key decision-makers and to have a high degree of power and autonomy. This makes their attitudes towards performance and financial information critical to the success of NPM (Jacobs et al, 2004).

The difference between the clinical and administrative staff's knowledge regarding economical aspects and accounting information can be high (Landry and Knox, 1996). The clinical professionals need to be efficient managers of scarce resources and understand the different cost implications of alternative procedures while maintaining the qualitative aspects of the care (ibid.). In order to achieve this, previous studies have underlined the importance of educating the clinicians in management accounting and providing them with the information they need. In that way the clinicians can be able to adapt to the changing demands of measuring performance and other representations of accounting information (Kurunmäki, et al., 2003; Goddard et al., 2000). This integration of accounting practices and the medical staff might also lead to an increased feeling of being able and willing to take responsibility for the measured performance (Jacobs et al., 2004).

3.3.2 Perceiving Performance Measurements

To better understand the use of PMs in a PHC organization, one way is to look at the pressure exerted by different groups of stakeholders upon a clinical unit e.g. the conflicting relationship between the purchaser and provider, as well as the more internal relationship between the operational levels and the management at the clinical level (Brignall and Model, 2000). Regarding BUP, apart from satisfying the demand from the purchaser, the managers of providing units also have to take into account other stakeholders interests and information requirements, such as the ones deriving from SocS (Socialstyrelsen, 2013).

The purchaser has to take a broader spectrum of factors into consideration than the provider, which leads to a need to simplify PM in order to make it more manageable. This can often lead to a larger focus on the monetary aspects of increased efficiency and cost reduction when it comes to prioritizing in the trade-off between the quality of outcomes and the cost of the services (Brignall and Model, 2000). The controlling role of the purchaser is also complicated by the distance from the operations performed by the providers of healthcare services. To counter this, quantification and the use of accounting techniques can enable what Robson (1994) refers to as "control at a distance". By the use of accounting information, various spatially dispersed sets of information can be simplified and made visible for the principal. In that way the principal can be better able to manage the performance of subjects that are separated in time and place (Robson, 1994).

Regarding the BUP clinics of Sweden, the increased importance that has been given to measuring productivity and efficiency has led to the managerial logic taking a higher hierarchical level of importance over the old ruling professional logic, leading to something that Arman et al., (2014) have chosen to describe as an "hierarchization" of competing logics. Quantitative measurements are used in order to legitimate the managerial perspective. Efficiency in meeting the ordained targets such as patient visits is thus prioritized over other more tangible aspects of quality that are harder to define (Arman et al., 2014).

One way of explaining how formal control systems and the use of performance indicators sometimes are perceived as positive and sometimes as negative in an

organization is to look at the framework of enabling and coercive formalization as presented by Adler and Borys (1996). If the operative managers perceive the formal system as enabling and helping them to achieve their work tasks it will be seen as positive. On the other hand, if managers feel that the system is a mean to coerce them into following the strict control imposed by top management, it will be perceived negatively (Adler and Borys, 1996).

In order for the control system to be seen as enabling, some aspects are of particular interest. The control system must be flexible and the users must be able to repair certain performance indicators in case of a problem, being permitted to slightly alter the measurement. Apart from this, the system must also be transparent both internally and externally in order for the users to understand the meaning of the system and be able to see the bigger picture. By operating a transparent control system, the user can obtain a better understanding of what implications individual work tasks have on others, both up- and down-stream (Adler and Borys, 1996). This can be achieved if the system is created to fit the organization (*ibid.*) and if the managers are involved in the development of the system and adhering performance indicators (Jordan & Messner, 2012).

The operational managers want to have a system that is enabling the use of performance measures. However, this often stands in conflict with the top managements need to be able to control at a distance, often implying a more coercive usage and the creation of tension between the two different levels (Ahrens and Chapman, 2004). The coercive logic is mainly fostered within organizations with power asymmetry, which allows managers to shape the extent and type of formalization. Instead, enabling logic requires and advocates less disparity of power, skills, knowledge and rewards between managers and subordinates (Adler & Borys, 1996). Management control systems and performance measurement in particular, may be specifically prone towards being used coercively due to concerns of performance evaluation and a strong hierarchical thinking (Ahrens and Chapman, 2004).

In addition to the key features needed to be in place when designing an enabling system, the question of incompleteness of the accounting information needs to be addressed. Accounting information is often unable to describe the whole picture of a certain performance, which can create an incomplete representation of organizational performance (Hopwood, 1973). In order to be able to measure a certain complex outcome of a process in PHC, the purchaser has to choose an indicator that in some way represents this outcome. As previously discussed, this will nevertheless lead to an incompleteness of the indicator as the indicator is not likely to give a full picture of all the factors effecting the outcome. The actions of the purchaser and provider will be based on their perception of the relationship between the efforts performed by the provider to reach a certain target and the relationship between the measured indicator and how well this actually reflects the outcome. This leads to two different problems of incompleteness: that of the measurement itself, but also that of the understanding of the relationship between the providers' performance and its effect on the outcome may be incomplete. This can in turn lead to various problems such as: tunnel vision, sub-optimization and myopia (Goddard et al., 2000).

Jordan & Messner (2012) implicate that the flexibility and repair criteria presented by Adler & Borys (1996) can be seen as solutions to issues of incompleteness. Flexibility is useful in tackling incompleteness of accounting information as it means not only relying on accounting numbers. The repair feature is useful in facilitating ongoing discussions about the strength and appropriateness of certain measures. The additional aspects of

transparency are then viewed as essential for the recognition of incompleteness (Jordan & Messner, 2012).

The way in which top management uses control systems in order to influence the behavior of the lower operational levels can be seen as a process of “sense-giving” (Jordan and Messner, 2012). This is of particular interest regarding incomplete indicators that has a much wider spectrum of possible meanings and usages. Sense is given through the usage of a control system and in the way that different PMs are being communicated in terms of their purpose and relevance.

Depending on how top management is putting significance on these different PMs they will appear as more or less enabling (or coercive) for the operational managers (ibid.). The notion of having to cope with incomplete measures does not necessarily mean something negative per se, as long as the operational managers and staff can handle them in a flexible way. However, such a flexible approach might go against the top managers’ desire of stable and more simplified measures that allow them to exercise control at a distance. In that case the top management may choose to reinforce the indicator as is, leaving no room for other interpretations or usages. In such an occasion the incompleteness of the indicator is likely to appear more problematic as the operational level may feel coerced and restricted, to using PMs of a lesser-perceived value (ibid.).

There has been a substantial increase of the significance that has been given and communicated regarding performance indicators in the PHC of both UK and Sweden (Goddard et al., 2000; Brignall and Modell, 2000). This push to focus on some PMs might lead to unintended consequences as the providers might behave in other ways than the purchaser had planned (Goddard et al., 2000). Due to the exerted pressure upon clinical managers, the use of PMs often takes the form of legitimacy seeking rather than efficiency maximization (Brignall and Modell, 2000). The pressure to account for certain PMs and focus on these, regardless of the perceived utility of these specific indicators from the clinical operational level’s point of view, can also have the effect that the operational level develops and uses their own internal indicators and systems of measuring performance in order to fully be able to assess all the aspects that they find important. However, such indicators can be perceived as having no real managerial concern since they are not linked to the evaluation of the performance that is reported to the purchaser (ibid.).

3.3.3 Accountability

The term accountability is both complex and common within the public administration literature and the word has expanded over the previous decades (Mulgan, 2000). A simple definition of accountability could be “the willingness and ability to explain and justify one’s acts to self and others” or “the procedures and processes by which one party justifies and takes responsibility for its activities” (Munro & Hatherly, 1993; Emanuel and Emanuel, 1996). It is external, involving social interaction and exchange and implying rights of authority (Mulgan, 2000).

In PHC the notion of accountability is also more complex due to the demands of many different stakeholders *to whom* one is being accountable and that there are several different aspects of *what* an individual has to account for. The doctors at the clinical levels are accountable for their actions and the performance not only to their managers, but also to the patients and colleagues. Furthermore, they are simultaneously

accountable for these performances in several different ways including: legal, ethical and financial terms (Emanuel and Emanuel, 1996).

The term of accountability can also be viewed as central to how individuals at different levels of an organization perceive and use PMs. In order to be able and willing to take responsibility for a certain PM, its purpose and practical features must be understood. Due to the complexity of measuring quality, the purchasers want to simplify in order to be able to better compare the results in terms of performance, leading to the usage of simpler and more quantifiable PMs of quality (Brignall and Model, 2000; Arman et al., 2014). Such quantification can also be seen as a way for management to facilitate the practice of accountability (Goddard et al., 2000). The simplification of complex indicators can enable the users to better be held accountable for their performance to the management, due to the increased transparency of such indicators (Arman, et al., 2014). This quantification in combination with how the management is stressing the importance of certain indicators might further enhance the pressure on the operational level of being accountable for the focal performance (Goddard et al., 2000; Jordan and Messner, 2012). As a result of being evaluated through more PMs in the PMHC during the last decades, the BUP units have been made increasingly more accountable for their unit's production and utilization of resources (Arman et al., 2014).

3.4 Summary

Measuring performance in terms of productivity, efficiency and quality can be a complex task in PMHC. This can be further problematic in BUP due to the inter-relationship between the provider and other principals that are involved in the treatment of the patients. Quality is also based on several different aspects in the structure and process of the treatment and it can thus be problematic to define what determines a good end result by means of looking at isolated PMs. Due to the complexity and the increased demand to present performance results, the purchasers and top management often choose to simplify the measurement in order to obtain more quantifiable PMs. This leads to the usage of many incomplete indicators. Such incomplete indicators do not comprise any negative implications for the operational level per se, but depending on whether the top management allows for a more flexible usage or not and how transparent they are, this may have an effect on how these are perceived as either enabling or coercive. The simplification of indicators in combination with how the top management is stressing the importance of these might also enhance the pressure on the operational level regarding its accountability for certain PMs.

4. Empirics

Unless otherwise stated, the presented data in the following section stems from the interviews and supplementary questions. First, a description of the roles of the interviewees will be given, along with a presentation of the structure of the public healthcare within VGR. Second, a presentation of the researched performance measures will be related. Third and finally, the empirical findings from each interview will be presented to display the perceptions of each separate level.

4.1.1 Interviews at Different Levels

The interviews have been held with different persons at the purchaser level according to the distinctive decision structures concerning the researched PMs. For the *productivity measure* interviews have been conducted with the following levels: HSN 4/HSNK, the management of the Psychiatric clinic, and the operational manager of BUP X. For the *SIP* interviews have been conducted with: HSA, the management of the psychiatric clinic, and the operational manager of BUP X.

Level	Description	Interviewee	Subject	Date	Additional
Purchaser	HSN 4/ HSNK	AK and MF	Prod	14-04-23	+ e-mailed supplementary questions
	HSA	MG	SIP	14-03-24	- -
Provider	PC at KS	KA and GE	Prod, SIP	14-02-26	- -
	BUP X	A	Prod, SIP	14-03-21	- -

4.1.2 The Interviewed Employees

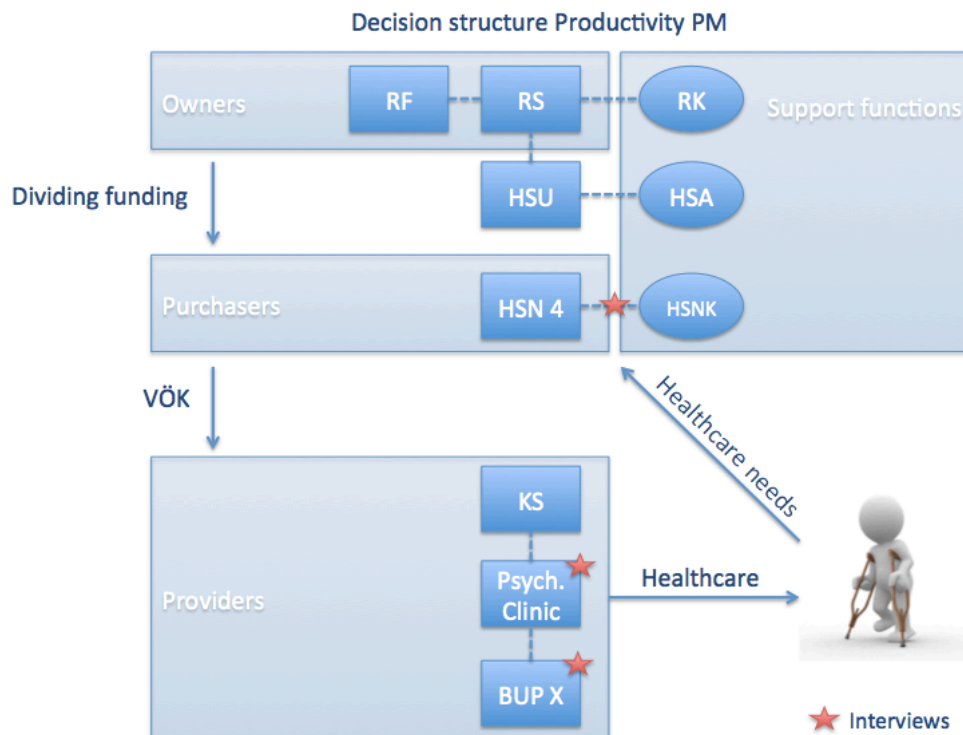
- Anna Karlsson (AK) – Head of Planning at the Healthcare Committee administration’s section 4 - **HSN 4** – **purchaser level**. HSN 4 orders the care package that specifies the performance targets for the provider Kungälv’s Hospital (KS). AK has worked at HSNK since 1999 and is in charge of the support function linked to HSN 4. AK is involved in analyzing and advising the committee in charge of procuring healthcare services from KS.
- Marika Fixell (MF) – Head of Planning at the Healthcare Committee administration – **HSNK** - **purchaser level**. As opposed to AK at HSN 4, MF’s position at HSNK is not focusing solely on section 4, but acting as a support function that is generally oriented towards additional organizations within the region. MF was previously Head of Planning at HSNK for eight years and Business Developer at Salhgrenska University Hospital for three years.
- Maria Grip (MG) – Development Leader at the unit for Psychiatry, Rehabilitation and Aid – **HSA** - **purchaser level**. The unit is responsible for the distribution of

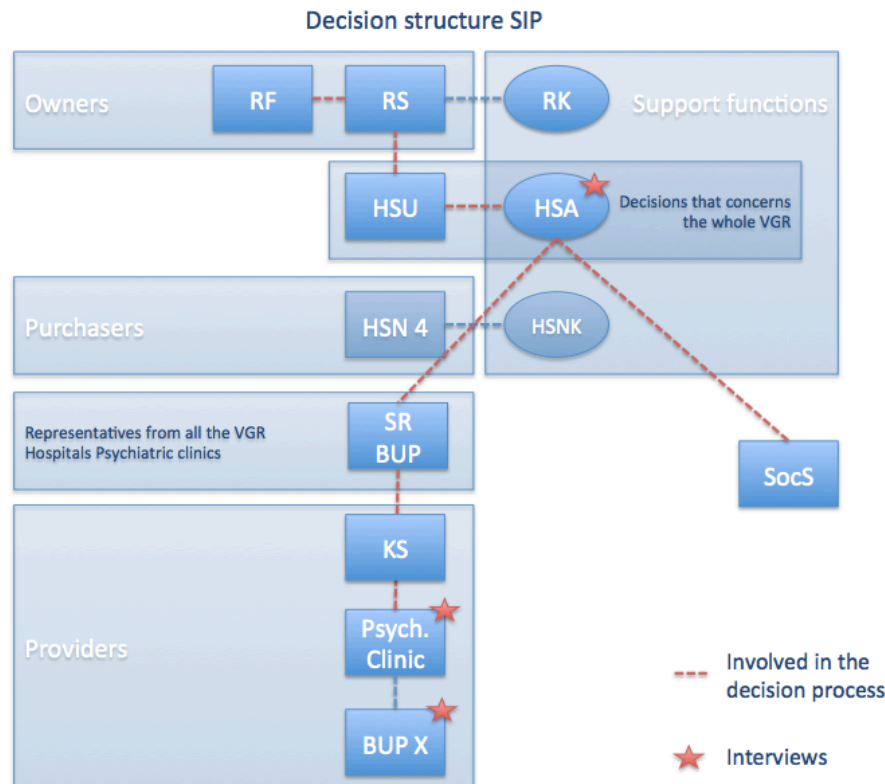
state funds regarding psychiatric care, including the performance-based remuneration linked to the SIP. MG has been working at her current position since September 2013.

- Katarina Andersson (KA) – Chief of Operations at the psychiatric clinic – **PC at KS - provider level**. From a hierarchically perspective, the PC is subordinated to the purchaser level, but is responsible for the management of the operational level. KA started working as a psychologist and has previously been Head of one of the units before she in 2011 started to work as Chief of Operations at KS psychiatric clinic. KA is also a board representative of the hospital and a member of the BUP sector counsel (SR BUP).
- Göran Eiman (GE) – Deputy Chief of Operations at the psychiatric clinic – **PC at KS - provider level**. GE has many years of experience working in the psychiatric care and has been involved in the formulation of PMs and the ongoing discussion regarding productivity and other indicators since the mid 1980s.
- Anonymous (A), Operational manager at a Child and Adolescent Psychiatry unit - **BUP X - provider level**. BUP is the operational level of the provider. A has a long clinical working experience and has been active several years at A's current position. A is responsible for the unit's provision of psychiatric health care services according to the VÖK formed between KS and HSN 4.

4.2 Organization

4.2.1 Organizational Decision Structure





4.2.2 The Structure of PHC in VGR

In Sweden the majority of all healthcare services are provided by public healthcare organizations, where the local counties provide the largest part of the services (scb.se). In 2012 the total sum of healthcare expenditures provided by the counties amounted to 276 billion SEK (skl.se_1), which accounts for roughly 17% of the total taxes funded by the Swedish citizens (swedbank.se). These funds are then distributed between the 20 different counties/regions in Sweden - counties being the standard geographical area and region being a county with extended responsibility for a larger area (skl.se_2). One of these regions is the Västra Götaland Region (VGR), which 2014 has budgeted expenditures of around 55 billion SEK out of which the PHC constitutes the majority (vgr.se_1).

The PHC in the VGR is managed by elected politicians in the local regional council (RF), together with the local regional board (RS). The VGR applies something called “the purchaser-provider model” (BUM), where the roles as *owners*, *purchasers* and *providers* have been separated and redefined (vgr.se_2).

The RF and RS decide upon the distribution of the funds to the different parts of the region and constitute the *owners* in the BUM. HSU is a committee that forms part of RS and are responsible for the overall planning of the healthcare in the VGR. To aid the decision making process the *owners* have different officials (situated in RK) that analyze needs and make calculations to support the political decisions. One part of RK is HSA, which is a support function linked to HSU (vgr.se_2).

Within the political sphere of the region there are also specific Healthcare boards (HSN 1-12) in charge of analyzing the needs of the different municipalities and hospitals and consequently setting up goals and budget terms on a more detailed level. These units constitute the *purchasers* of the BUM. HSN4 is the board in charge of the procurement of PHC for the regions of: Tjörn, Öckerö, Kungälv, Stengunsund and Ale. All the different HSNs also have a support function of officials in the form of HSNK, giving support in

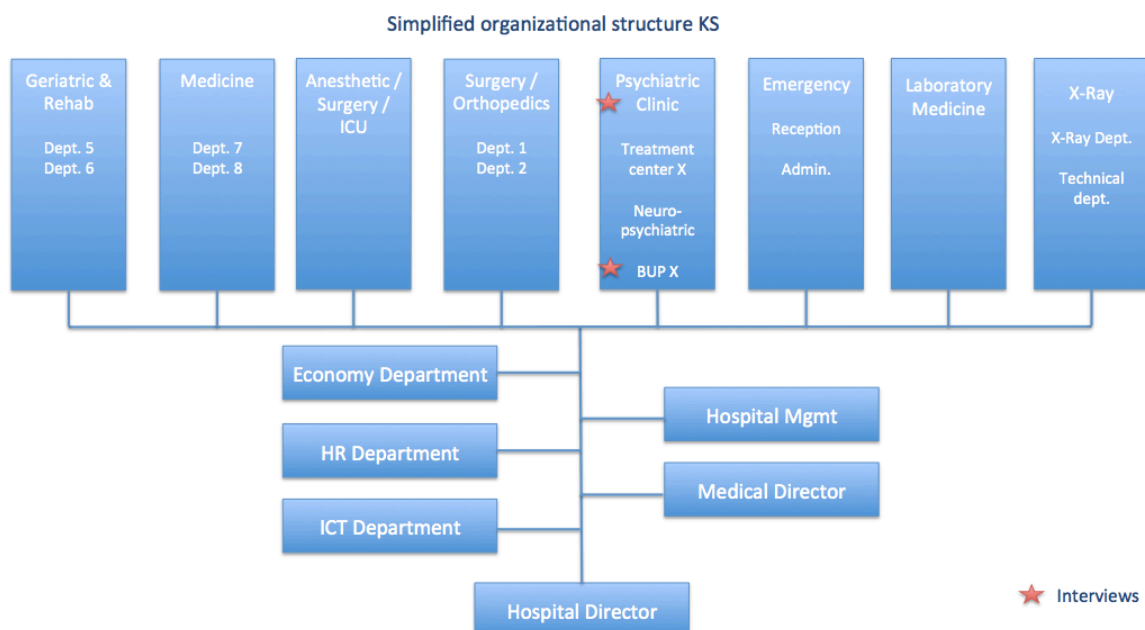
much the same way as RK and HSA does to HSU and RS (vgr.se_2). Depending on the identified needs of the different areas/hospitals the purchaser forms two-year contractual agreements (VÖK) with different suppliers of the service, regarding the amount of services, the quality of the service, etc. These suppliers constitute the *providers* of the model and are made up of mostly public hospitals, but also private healthcare organizations and other caregivers (vgr.se_2).

The roles of purchasers and providers and the relationship between these in the BUM are central to this study. A simplified way of explaining the difference in roles is that the purchasers focus on *what* needs to be done and the providers on *how* to provide this (Hallin and Siverbo, 2003). The contractual agreement, VÖK, allows the politicians to separate themselves from the operations and control from a distance. This requires a good balance between the dual roles of the purchaser; being both a representative of the PHC needs of the community and a controller of the provision of healthcare services (ibid.).

Within the VGR there are eighteen different public hospitals divided between four different groups of hospitals based on their geographical distribution. Furthermore there are various different local, smaller, healthcare centers (vgr.se_3). Our study is set in the context of the PMHC at KS.

4.2.3 The Organizational Structure of KS

KS has 1166 employees covering the hospitals catchment area of 122'000 inhabitants. Every year KS provides around 12 000 treatments and has around 97 000 patient visits (vgr.se_4). The total budget for 2013 accumulated into slightly less than 1,1 billion SEK out of which 866 million came from HSN 4 in accordance to the agreed upon VÖK (KS Annual report, 2013). The hospital has four different administrative functions and is led by the Hospital Director assisted by a management team comprised of the different chiefs of departments and staffs (vgr.se_4). KS consists of eight different clinics, with coherent subdivisions. The focus of our study regards the outpatient treatment of Children and Adolescents with mental illness at one of the three units involved in this work: BUP X.



Source: Simplified interpretation based on KS organizational chart (vgr.se_5).

4.3 Description of the Performance Measures

4.3.1 The Productivity Measure

The principal idea of having the productivity PM linked to the performance-based remuneration is to stimulate the productivity. It forms part of a compensation model for distributing the funding from HSN developed with the purpose of promoting cost control and increase productivity (HSA, 2010). The productivity measure is subject to the ordered volume of produced healthcare in the care agreement (VÖK) between HSN 4 and KS. Out of the 866 million SEK, that KS received from HSN 4 in 2013, 18,6 million SEK were allocated to BUP; 50 percent of these grants were in the form of a fixed compensation and 50 percent were performance-based. The performance-based remuneration is connected to meeting the required volume in terms of patient visits. The ordered amount of patient visits were specified to 7 109 for the totality of the three BUP clinics of KS out of which roughly a third considered the planned production at BUP X (VÖK 2013-2014).

The productivity measure that is used only includes patient visits defined as: “...a personal meeting between the patient and caregiver.” (vgr.se_7). Additional consultations that are performed with parents or representatives from the school where the patient is enrolled are thus not part of this indicator (nor of any other productivity measure included in the VÖK). Furthermore, no consideration is given to the number of employees meeting with the patient during a visit. Hence, only one employee can report and account for the visit. Which employee that will account for the visit is decided based on a ranking arrangement relating to their profession. Ranking from 1-4, physicians are prioritized, followed by psychologists, curators and finally nurses. Thus, if a physician meets with three patients during one day together with a psychologist, the latter will remain without any activity to report.

4.3.2 The SIP

Samordnad Individuell Plan (SIP) – Coordinated Individual Plan – is, as the name describes, a coordinated plan between different principals involved in the treatment of patients with a special need of this kind of integration and is also used as a performance measure of quality. It was introduced on the basis that the previous structure for arranging the involvement of different actors such as schools and social services when treating children and youths for mental illness was too sprawling and uncoordinated. In order to make the coordination of the separate actors more effective and structured, it became statutory in 2010; When the individual is in need of intervention from both social services and healthcare, an individual plan must be coordinated between the county council and municipality if either part finds this necessary and if the patient agrees to this (SoL 2:7 §; HsL 3f §).

SIP is one of the PMs included in a larger national performance-based compensation packet, which is a part of PRIO. This package is an endeavor on the part of the SocS to treat mental illness. It was launched 2012 and will be in function until 2016. This venture strives to strengthen and intensify the development in the municipalities and counties through the use of stimulus funds and keeping the patient in focus (Socialstyrelsen, 2014). The aim with the duration of the plan is to create the conditions needed for a long-term undertaking that will leave permanent effects.

In order to take part of any of the funds deriving from the PRIO project, a county must fulfill two basic requirements: they must have an agreement in place regarding coordination of activities for individuals with psychiatric disabilities; and they must have a website informing adolescents and their families, of where psychiatric aid can be sought if required. Additionally there are several performance-based goals that also need to be fulfilled. SIP is one part of these. VGR must report back to SocS through submitting a report to SKL. This report accounts for the total number of patients for whom a SIP has been established; an assessment of the number of patients that were in need of a SIP but did not receive one; and a plan of how to see to the establishment of SIPs for these patients during the coming year [2015] (Socialstyrelsen, 2014). In 2013, a total of 630 million SEK was distributed from SocS's PRIO project to the municipalities and county councils in Sweden that had fulfilled the requirements. Out of these, 8 million SEK were allocated to performances related to BUP within VGR (HSU, 2014).

In the VGR the structure regarding the distribution of the funds are as follows: The funds that are allocated to VGR from SocS are distributed according to the needs of the various psychiatric departments, the PC at KS being one of them. HSA is responsible for analyzing how to best distribute these and confers with committees consisting of representatives from all the different psychiatric clinics in VGR (SR BUP, amongst others) before giving its recommendation to HSU. RS and RF then make the final decision and the funds are distributed accordingly to the different providers.

The funds from SocS to VGR are always paid the year after the performance has been assessed and *only* if the basic requirements are met also by at least 80 % of the municipalities in the region. VGR has nevertheless decided to distribute around 50/50 – pre-/post performance – taking a calculated risk since they might lose the money paid pre-performance if the goals are not met in the end (HSU, 2014). The reason to do so 2014 is the same as it was 2013; based on the good performance of the previous year and that it makes sense to receive funding during the actual period of the sought after increased development.

4.4 Empirical Findings

The following section presents information compiled from the interviews, supplementary questions and secondary data, describing the perceptions of each level regarding the focal PMs. The presentation of the empirical data is divided in accordance with the decision structures of the PMs, presenting the findings for each level separately. At levels where both PMs have been discussed, the findings will be divided into two parts.

4.4.1 Purchaser Level, HSN 4/HSNK - Anna Karlsson and Marika Fixell

4.4.1.1 The Responsibility and Role of the Purchaser and Provider

In order to better comprehend how PMs are perceived and utilized at the purchaser level it is important to clarify how the representatives at HSN 4 view the disparate roles of the purchaser and provider of the BUM. As explained by AK, the main task for HSN 4 is to represent the local public and see to that the supply of healthcare services is secured through the provision of different providers. The hospital board of KS is subsequently the entity responsible for providing the healthcare in an efficient and responsible way according to the ordered supply agreed upon through the VÖK. This

division of the roles is due to the BUM being used for all the planning and supply of the healthcare in the region. This leads to that the VÖK and other forms of controlling the providers' actions for the owners and purchasers to mainly consist of more general strategic goals and parameters. The level of detail is supposed to be kept low in order to allow the hospitals to maintain a certain level of flexibility in how to best utilize their resources. MF points out that this division is also described in the official policy document regulating the compartment of the board of KS:

- *"The providers shall monitor the operations in a way so that they are being performed and developed in congruence with the decisions that have been made at RF and according to the assignments of HSN" (vgr.se_6).*

The view of the purchaser's role can be summarized in the statement from AK as:

- *"The politicians making the decisions are representing the public and not the operations of the providers."*

4.4.1.2 Perceived Purpose of the Productivity Measure

The productivity that KS and the coherent BUP units are to deliver is stated in the agreed upon VÖK in terms of number of patient visits. The specific amount is based on the demand deducted from the analysis made by the purchaser, which also stands in accordance to the amount of patients that the provider has deemed in need of receiving mental healthcare services. The purchaser also takes into consideration quantities derived from benchmarking against other similar regional units. The total amount of patient visits is thus agreed upon through a negotiation process between purchaser and provider. Through the VÖK, HSN 4 sets targets regarding availability, defined in terms of opening hours, waiting times, how to receive the patients and certain qualitative requirements of the treatment that have to be fulfilled. The VÖK also includes general guidelines on how the hospital should provide the healthcare in an efficient way:

- *"...Available resources [should be] utilized in the best way possible in order to achieve set targets. The healthcare should be... ...provided in coordination with other providers based on the difficulty [of the state of the patient], value for the patient and cost efficiency." (VÖK, 2013-2014).*

However, the purchaser does not set detailed descriptions regarding how the provider ought to meet the targets regarding productivity e.g. in terms of how many patients a doctor should see per day. The role of the purchaser is to see to that the overall aspects of the VÖK are fulfilled within the budgetary framework; the detailed planning and provision is left to the caregiver.

4.4.1.3 Evaluating Productivity

The evaluation of the produced HC services is performed several times a year and some aspects are followed up every month. The main agreement, VÖK is currently formed on a two-year basis; however, the procurement and content of the agreement is updated and decided upon each year. The purchaser does not assess the production in terms of efficiency or at a detailed level linked to the utilized resources, as cited below:

- *"The production [of patient visits] is followed-up in terms of raw amounts and not in terms of productivity".*

Furthermore, as stated by AK, it is essential that all the evaluation be made through a dialogue between KS and the representatives at HSN 4. This cooperation is working very well between the PC of KS and the purchaser (compared to some other hospitals in the region) since the PC is keeping them informed of any variations between output levels and planned productivity. In that sense follow-ups are facilitated, as the purchaser is made aware of changes in the production and the causes for these deviations in a straightforward manner.

4.4.2 Purchaser Level, HSA - Maria Grip

According to MG, the purpose with the SIP is drawn from the previous operational reality, which contained too many plans and the procedure for treating children and adolescents, was too complex when aid was needed from both the municipality and county council (the principals). These issues facilitated the focus on SIP on behalf of SocS.

- *“The SIP is a quality indicator that clearly states a demand for structure and coordination regarding how the coordination is to be undertaken.”*

There is an original agreement between SKL and the government stating that, along with the reports on SIP usage levels, the reporting units ought to create action plans for the future increases of these levels. BUP reports on the number of completed SIPs, but are also to provide an estimate of the total demand. The action plans' purposes are to decrease these gaps, but there is no specific target and there is no discussion on the matter. In all, the chain of communication is rather vague.

- *“I guess it looks a bit different at each administration regarding how clearly they perceive that this [SIP] is what they get money for, which is one obvious problem if you want a management effect.”*

The perception at HSA is that the operational units perceive the SIP as a positive tool and that when the SocS and RF make an assessment that concludes a specific development aspect as topical, the operational units increase their focus on these matters. It is not necessarily what they would have focused on if they were autonomous; however, since governmental funds are in this case directed towards increased activities regarding SIP, the independent ideas become secondary.

- *“That is what I believe is the true management control in this case.”*

However, outcome measures are generally difficult to measure in healthcare. Hence, the effect of using SIP is not determined. Some units have a clearly structured procedure for the usage of SIP, with additional alignment between the regions and municipalities and an agreed upon definition of the rationale for using SIP and the meaning and procedural requirements it entails, whereas other units merely have the formalities in place with little attempt of discussing the rationale. The awareness of the differences between specific units' efforts in structuring the implementation and usage of SIP is derived from the only attempt to assessment of SIP that has been made. The experience of HSA regarding this has been that it is difficult to gather a number of professionals and tell them that they must do something without offering an explanation.

- *“The concern with the outcome measures is in this case that if you consider a child, whom has had troubles and been ill and suddenly starts becoming better,*

there are so many factors to account for that you can not at all be certain that it has anything to do with the principals' coordination in itself. It could instead depend on something else, such as the mental state of a parent changing to the better. The principals can have coordinated themselves in a very good fashion, but if a parent continues behaving violently at home this will not matter. That is what is difficult with these types of measures and I do not know how this [evaluation] has been treated."

4.4.3 Provider Level, PC at KS - Katarina Andersson and Göran Eiman

4.4.3.1 The Evaluation of PMs

An evaluation regarding the different PMs that are linked to monetary compensation depending on their fulfillment is performed twice each year, in April and August. The evaluation in August can be seen as the most important since the presented results of the performance levels at that time will lead to the amount of compensation that the clinic will receive in the end. A lot of these PMs are not regarded as measures of efficiency but rather as simplified productivity measures as is the case of the focal productivity measure. A lot of what is being evaluated is also not quantified and formulated in specific productivity targets, but rather seen as aspects of what the provider should achieve in terms of working towards different operational targets

This notion of measuring performance is also something that is still rather new to the PMHC and the usage of PMs. The PMs used in the PMHC are often not as developed compared to PMs employed in the somatic care (vgr.se_7). This has in some cases lead to frustration amongst employees questioning the usefulness of these measurements for giving the right healthcare treatment.

- *"Before, we did not have to comply with so many aspects of PMs. This has evolved from the somatic care and then they have tried to transfer this thinking into the mental health care. Some of the things that this has been brought with the measuring has been seen as strange and not having an optimal fit with our processes, such as how the administrative part of the registration should be performed... ...a way of working that is frowned upon by some. This can in some cases lead to some frustration amongst the operational level as they might not see the full picture and how these various PMs are important and useful for treating the patients in the end."*

4.4.3.2 The Decision Hierarchy Regarding PMs

The decisions regarding the budget and the productivity and quality measures are agreed upon through a discussion between KS and HSN 4. The involvement of PC is based upon a dialogue between PC and KS and then taken into account as the performance targets and budget are fixed in the contractual agreement (VÖK) that is the result of this. The amounts fixed to these different targets are largely based upon the performance of the previous year with a calculated deduction of a certain percentage meant to be based upon the expected increase of efficiency.

- *"The decision structure is slightly different if you look at other hospitals. At the larger hospitals of the region this communication can be much more disconnected, but here at our smaller hospital we have a much closer relationship between the management of the hospital, the HSN and the different units of the hospital. The*

whole process of the management accounting is therefore much closer and possible to influence for us.”

4.4.3.3 Perceived Purpose of the Productivity Measure

The calculations is based upon the notion that every treating physician should be able to meet with two patients per day, after deducting days of sick leave, part time employees, etc. When multiplied, this leads to an estimation of the total production that are then communicated to the NHS 4 and decided upon after a negotiation process.

- *“We are highly involved in the process of how to set these goals for the performance. To estimate a reasonable level of production, it is all based on simple mathematics and common sense... ..This is not any political decisions, but rather a reflection of how reality looks like, more or less here in this room [the office of KA].”*

The productivity PM is viewed as a form of operational follow-up measure having a historical connection to the patient register at SocS where every patient visit were previously reported from all different sectors. Those statistics included facts such as diagnosis, etc., but did not take into account other visits that were made to other staff than doctors.

- *“...So you will not get a complete picture of the productivity. ...We use it since we do not have anything else that is better in terms of measuring productivity. “*

According to the respondents, BUP is the unit that in this sense has been the most complex unit to measure in terms of productivity. There are many different kinds of visits that are not being registered e.g. if a patient is seeing both a doctor and a nurse, or if a doctor is seeing other principals involved in the treatment of the patient; this will not show up in the statistics. Another aspect that the PM fails to include is the complexity of the individual patient. Some patients require more resources and several longer meetings. However, this cannot be seen in the registered visits, as they do not include any information of duration.

The fact that many visits are not being registered is seen as somewhat problematic. All the things that are produced are not included in the statistics that are being reported to HSN. Many of the involved operational employees are complaining that they are working, seeing patients, but that this cannot be seen in the numbers. This has lead to the talk of “performance visits” and other visits.

- *“The “performance visits” are those visits that qualify for being counted as a patient visit and the other visits can help us keep track of everything else that is being performed but not included in this measure. This division is however only used for some internal references, so that we can see what is being done.”*

4.4.3.4 Perceived Purpose of the SIP

According to KA and GE, the patients that need interventions from both the PHC and the municipalities are a prioritized group. The purpose of using the SIP is a belief that coordinated interventions at an early stage will lead to the prevention of recurring treatments. Without these interventions the patients could be at risk of falling in between the different principals. Regarding BUP it is important to work interdisciplinary between both BUP and other principals such as the school and social

services. It is also important to find a way of including the parents in the treatment process. By using a qualitative measure such as the SIP this cooperation can thus be made easier. There can however be some differences in terms of communication and frameworks between the municipalities and the BUP units that some times may increase the complexity.

The management accounting within the PC is seen as another complex aspect due to the fact that the funding received originates from different sources. The main budget for the PC of KS consists of the 164 millions deriving from the funds from NHS 4 (VÖK, 2013-2014). The other parts can derive from different national projects such as the compensation package linked to fulfilling the performance requirements of SIP. The compensation regarding SIP is paid out at two different times: 50 % before the budgeted performance and 50 % post performance depending on goal fulfillment. Due to the time difference it can therefore sometimes be difficult to link the monetary compensation to a specific historical accomplishment. This part of the funding is however much smaller, a few millions compared to the total budget.

- *"...Nevertheless every penny counts as we have very slim margins to work with and are currently running on a slight budgetary deficit. This way of including future compensation in the budget can however lead to an increased deficit as it is a risk that these funds might never be received."*

The purpose of the SIP is further seen as somewhat abstract. The respondents are not aware of any specific targets that are supposed to be met in terms of performance measurement. Nor have they been informed of any outcome evaluation regarding the effect of using SIP in terms quality.

- *"Not to our knowledge [are there any evaluation occurring regarding the effect of using SIP]. At present time the goal is to use the SIP for the patients in need of such a plan of coordinated intervention."*

4.4.4 Provider Level, BUP X - Operational Manager A

4.4.4.1 Perceived Purpose of the Productivity Measure

BUP is a palpably small part of Swedish healthcare and therefore also an inheritor of measurement control systems developed for larger somatic PHC sectors, such as surgery. One of the control systems in place is the productivity measure. This PM is regarded as unfit for the small and specialized BUP. The unit's perception is that there is no point in debating this situation, since nothing is ever going to change anyhow.

- *"It is like shouting out in space and there are better things to do."*

The unit perceives the PM to be strange and non-functional for several reasons. At BUP X, each employee is to produce 10 activities a week, equaling 2 patients a day. This is internally regarded as a very modest goal, on the point of being ridiculous, since the duration of a patient meeting is generally one hour. However, in addition to the single patient meeting, a number of meetings with external actors must be coordinated and held, e.g. with the school, social services and other members of the patient's family. Since the PM measures productivity in terms of patient visits, these meetings are not registered into the accounting system. In addition, in some cases the child (patient) is not partaking in any meetings and activities instead circle around the family and other stakeholders, leading to none of the activities being registered. Hence, the unit perceives

a gap between actual output and measured “productivity”. Further distress is caused by the fact that only one employee can register a meeting with a given patient, although more than one employee often partakes. Which employee is allowed to register a patient visit is decided by the previously mentioned ranking system based on the title of caregiver, commented by A as:

- *“If we are 4 persons there will still only be one activity registered. The system measures very bluntly. This order is window dressing. It does not measure anything. In my opinion it should have measured a lot more.”*

Due to these circumstances, PM is perceived as a blunt instrument for measuring productivity since the unit regards other activities surrounding the actual patient meeting as requiring the same effort. A’s perception is that the PM ought to include additional activities as to capture how many meetings each employee actually partakes in, making the all the activities conducted visible. He suggest either creating a system where each meeting, regardless of participants, is included in the PM, or a ranking system where different scores are given for different types of meetings, although capturing all meetings in order to close the perceived existing gap. This would, according to A, allow for a performance measuring of what they really do and thus, create a tool that is actually useful and interesting, although A does not see any point in communicating these thoughts.

- *“There is no dialogue except when developing care programs. Then there is space for discussing the content and get attention for this. But the political stuff, it just to show up and maybe some chief of operations can argue, but not an operational manager or someone treating patients. That does not happen. BUP has been regarding this measure system as a bad instrument as long as it has been in use, thinking it does not measure anything. It covers so little.”*

The personnel ignore the productivity activities and perceive the PM as scary due to the fact that they are being checked, which according to A concerns both employees doing too little as well as employees doing too much. It is believed to be some invention made by HSN, without the participation of the politicians. The attitude is of a negligent nature, regarding the PM as unimportant for the assessment of the unit. Although all patient visits are reported to the accounting system, A’s perception is that there would be no sanctions if targets were not met, stating that the deputy Chief of Operations calls if a patient is not diagnosed, but not regarding the productivity PM.

- *“If we simply ignore the productivity activities I do not think anything would happen in the next five years. And everything is very sluggish in healthcare, it takes a long time before you cut or add employment. BUP Y has probably never reached their target and up to date, nothing has happened in seven years. On the other hand, the politicians cannot just let it go and give us money and tell us to do as good as we can. There must be some form of management, otherwise it does not work. It is just that [the productivity PM] is so blunt.”*

The hesitant attitude towards the functionality of the PM results in an alternate usage internally within the unit, serving as a tool for A as operational manager when “managing resources”.

- *“For me it is a small tool for managing resources. The productivity activities are up to me to nag about and tell the employees if they are doing too much or too little, but that is very unofficial and no one says they are to be used in that way.”*

4.4.4.2 Perceived Purpose of the SIP

- *"I believe that you must cooperate around these children. All the actors of society simply must help."*

According to A, the school must know how the child is feeling and adjust its education accordingly. The underlying purpose with SIP is perceived as a needed tool for structuring how BUP X is to coordinate activities with different parties. However, according to the operational manager, the efforts for coordination were already in place, before the implementation of SIP. The practical consequences of the SIP is thus described as primarily an additional administrative burden that could decrease the willingness of the personnel to see many patients since this entails so much paperwork.

- *"I do believe that it is very good that SIP has been introduced, but it is certainly an additional effort as well and after a while you reach a certain limit. How much paperwork are we really going to do?"*

For BUP X, there is a communicated target level for the usage of SIP in applicable cases. Nonetheless, according to A it is impossible to communicate such a target level to the employees since a target lower than 100 % signals the possibility of not establishing a SIP for some patients, and some could think that the colleagues would fill the quota. There is, according to A, no space for gray areas since nobody monitors these percentages, resulting in the operational manager communicating a target level of 100 %. However, after reporting the data into the accounting system, no feedback is communicated from higher hierarchical levels. Thus, except for the unit's internal verification of the establishment of SIPs and the patients and patients' parents taking part of the SIP's material, it is not used for anything.

- *"I think SIP is good, but this is not measured and it is just an assumption that SIP is good."*

The unit perceives the focus on SIP as a good intention, although stating that the implementation of the SIP does not profoundly affect the activities the unit conducts when coordinating efforts with external actors regarding patients. A underlines the complexity of assessing quality as central to the issues of measuring any effect of the SIP. A describes psychiatry as "a bit lost when it comes to quality". In addition, A adds that many patients have intertwined illnesses, with inherent cause and effect relationships. Hence, the reason for the patient's improvement is not seldom difficult to determine, and the effect of a chosen method of treatment is not independent of the individual's skills and qualities. As a further example of how complex it can be to measure qualitative aspects of the caregiving at BUP, A mentions how they previously had a tool similar to Qstar called "Barnstjärnan" (*the Child Star*), which had to be discontinued due to the complexity in assessing the quality outcome. The underlying reason for the abolishment of the PM was due to the lack of participation from the parents to fill in important variables needed to perform a full assessment.

5 Analysis

5.1. The Productivity Measure

The views of the productivity measure differ distinctively between the purchaser and the provider level regarding certain aspects. At the purchaser level, productivity is only viewed in terms of patient visits, with a clearly stated emphasis that the practice of including other forms of measurements mentioned at the provider levels is not taken into account, nor that they should be. The purchaser's standpoint, as representatives of the public, is that they should not be involved in the operational planning at a detailed level, nor to set standards regarding how the resources should be utilized in terms of efficiency. They order a certain amount of patient visits that has been agreed upon through negotiation with the provider and this is the totality of their involvement in terms of productivity. This way of not being involved at a detailed level is viewed as a result of how the purchaser and provider have separate roles to fulfill, deriving from the inherent responsibilities of the BUM.

The purchaser's view of the PM can be seen as adhering to what Slack (1999) refers to as the simplest version of what can define productivity: to look at one isolated aspect of input and compare this with the total output. In this case the input is in terms of the funding, indirectly translating into inputs of working hours, and the output is defined by the total amount of patient visits. From the purchaser's point of view this is a sufficient measurement since aspects of efficiency are deemed to not adhere to their responsibilities as representatives of the public, thus ought to keep their distance from interfering in more detailed operational planning. The procurements of health care services are to be kept simple and therefore there is no perceived need of having a more in depth linkage between the funding and the produced amount. This way of using a simpler version of measuring the productivity can be likened with the findings of previous research where purchasers of healthcare organizations have been found to strive towards employing simplified and quantifiable measures (Brignall and Modell, 2000; Arman et al., 2014; Goddard et al., 2000).

This view presents a clear distinction from the provider level's perception, which instead sees the PM as being insufficient due to the simplified nature of the indicator. The operational level views the PM in its current form as unfit for BUP, since it does not include certain meetings that encompass the majority of the tasks being performed. Neither is any consideration taken to how the targets of production are being met in terms of efficiency, which can lead to a false impression of productivity according to Linna (2009) and Ackerby (2008). Drawing on Goddard et al. (2000), the usage of an indicator that does not include various factors leading to the produced outcome can be perceived as incomplete. Such incompleteness can also be seen in the disparity between the perception of the provider and purchaser in terms of what kind of operational performance is having an effect on the outcome. This incongruence can be seen in the operational level's desire to include more aspects into the PM that they perceive as having a large influence on the produced outcome.

The purchaser's perception of the PM might be influenced by the role of the purchaser, defined by Brignall and Modell (2000) as having to be in control of a broad array of different aspects, leading to a need for simplifying the measures. This way of translating more complex processes into quantifiable measures can also be seen as a prerequisite to be able to exert control at a distance, as described by Robson (1994). This assumption is

further underlined by the formulation of the PM in the contractual agreement (VÖK), which, according to Hallin and Siverbo (2003), can be seen as a medium allowing the purchaser to distance themselves from the providers and control the operations at a distance. However, in order to achieve this Hallin and Siverbo (2003) also underlines the importance of managing the *dual* roles of the purchasers as of being *both* representatives of the public needs of PHC as well as being a controller of the provisions of healthcare services. The first role is underlined several times by AK at HSN 4, but the latter role seems to be a more absent aspect in the perception of the purchaser. This may imply a reason for how the productivity PM is viewed as a sufficient measure in its current form.

Both the operational level and the PC level see the PM as an incomplete indicator, which according to Jordan and Messner (2008) can have an implication on how a PM can be perceived as either enabling or coercive, depending on how it is being communicated and given sense from the top hierarchical level. In addition, the operational level perceives the PM as a design made by the purchaser, whereas the PC level perceives it as an internal decision to keep an alternative PM with its origin in traditional somatic care. The PC level believes this decision to have been made due to the perceived incompleteness of the PM employed by the purchaser. The origin of the usage is thus rather vague. These different views regarding the origin of the PM can be seen in the light of what Jordan and Messner (2008) describes as a lack of transparency, lessening the understanding of the meaning of the PM and a difficulty in grasping the larger picture of the individual role in coherence with what is being measured.

The view of the decision structure surrounding the PM is thus differing throughout the hierarchical chain. The operational level perceives the purchaser as having a more active role in the formulation of how to measure the productivity than what is expressed by the purchaser itself. The purchaser sees the planning and assessment of productivity that they are involved in as being separated from the internal design of the PM used at the provider level. The purchaser distances itself from this design of the PM employed at provider level since the purchaser itself does not view productivity through the lenses of this PM. However, the operational level sees the PM in its current form as based on directives from HSN 4 and that the decision not to include any other activities than patient meetings in the PM to have been an active choice on the purchaser's behalf. The operational level has in this sense not been made aware of the purchaser's view of their role as being first and foremost representatives of the public and, therefore, non-involvement in the formulation and usage of the PM.

The simplified PM employed by the purchaser is not used coherently throughout the hierarchical chain since both the provider levels perceive it as being incomplete. In accordance to Brignall and Modell (2000), this perceived incompleteness has led to a quest for alteration on behalf of the provider levels in order to include additional indicators that are perceived as important. Nevertheless, the purchaser does not identify a need for an alteration since the simplicity of the PM results in a control situation where the only indicator of performance is patient meetings, which are indeed taking place and being reported by the provider levels, regardless of discontent with the PM or usage of additional indicators. Drawing on Jordan & Messner (2012), the perceived incompleteness need therefore not be negative for the provider levels since the purchaser merely monitors one indicator and therefore leaves a high degree of flexibility for the provider to add additional indicators in an internal control system of productivity. However, due to the lack of transparency between both the different provider levels internally and between the provider and the purchaser, the provider levels are unaware of their degree of freedom and autonomy, simultaneously as the purchaser level fails to identify any discontent with productivity measurement.

These factors can thus be seen as examples of how the PM is given sense by the communication through the hierarchical chain from the purchaser through the PC level and down to the operational level and thus having an impact on how the PM is viewed as either enabling or coercive. According to Adler and Borys (1996) in order to be enabling, the control system must be flexible and transparent. Jordan and Messner (2008) further adds the importance of having a good fit between the organization and the PM and the involvement of the operational levels in the development of the indicator. However, this does not seem to have been the case in the researched organization and this notion is further complicated by the fact that although the PM is seen as being incomplete there is an absence of the possibilities to repair this issue. In the light of these factors the current PM can be viewed as being perceived as coercive in its current form and usage by the operational provider level. A consequence of the coercive nature of the PM and the perceived incompleteness of the PM has led to that additional measurements including other visits sometimes are being used for internal control purposes at both the PC and operational levels. This can be compared to the findings of Brignall and Modell (2000) where a pressure to account for certain PMs regardless of the perceived grade of utility can lead to the development and usage of internal indicators. In this way the provider can obtain a tool that includes more of the aspects that are deemed important to measure. However, since these indicators are not included in the performance evaluation linked to the purchaser and the coherent performance-based distribution of funds, they do not imply any real managerial impact.

A further outcome of how the PM is being perceived is the effect that this has on the accountability for the provider levels. Since the provider levels perceive the focal PM as being incomplete, they are expressing a sentiment of not being *able* to account for what they perceive as important aspects of what is being performed. In this sense, although the providing levels express a willingness to be able to account for more aspects of the production, this is not possible in the current state of how the performance is being assessed. It is notable that the relatively simple terms demanded for monetary compensation to the provider from the purchaser are perceived as merely negative since the various factors not included in the measure are possible for the provider levels to manage and control internally without interference from the purchaser level. However, the concept of productivity as perceived by the operational unit is not solely consisting of meetings with the patient, but closely intertwined with additional activities in order to generate good care. Thus, this perceived incompleteness in the discrepancy between PM in place and the provider levels' views on productivity, which is mainly relating to the lack of transparency throughout the hierarchical chain, overshadows the beneficial simplicity in terms of meeting targets to receive monetary compensation.

To conclude, the lack of transparency and hierarchical communication diffuses the purpose and practical usage of the PM throughout the organization. The simplicity of the PM used by the purchaser level in order to facilitate control at a distance is seen as incomplete and coercive by the provider level, which thus as a reaction internally adds additional features to measure productivity. However there is a misconception at the operational level regarding these alternative features of the PM as being a design chosen by the purchaser level, which further adds to the confusion within the organization. In addition, the seemingly beneficial terms for receiving monetary compensation at the provider levels are dwarfed by the provider levels' willingness to account for more aspects of productivity than are being measured today.

5.2 The SIP

All respondents throughout the hierarchical chain consider the SIP as a PM with inherent qualitative features. As stated by both the purchaser and the providers, it is not believed to measure or assess quality; however, they considered the SIP as having an intended purpose of increasing the quality of treatment. Their description of the PM matches the process category of the Donabedian model, where an assessment of the means and methods of the treatment are in focus, rather than an assessment of the outcome. When discussing the aspect of quality within BUP, all respondents stress the difficulties of assessing any individual methods of treatment due to the various, complex and intertwined issues that the operational level confronts when treating a patient. This can be viewed from the perspective of what Holmberg (2006) refer to as a high level of task uncertainty, which occurs when the identification of a “good practice” is difficult. Further, Holmberg (2006) stresses the importance of not routinizing processes with a high level of task uncertainty, which is in accordance with the SIP’s absence of quantifiable measures for assessment.

Although each respondent regards the underlying rationale for the implementation of SIP as reasonable and appropriate, they nevertheless differ in their respective views on the practical implications and consequences that the PM entails. The respondents at the PC level describe the SIP as facilitating coordination efforts, in line with the view of MG at HSA whom also perceives the governmental funds dedicated to SIP as affecting the efforts made by the operational units regarding cooperation. In contrast, the view at the operational level is that the efforts for coordination are already in place, that this way of working has been present even before the implementation of the SIP, thus describing the practical consequences of the SIP as primarily an additional administrative burden that, according to the operational level, for some employees instead can incite a demotivation to see patients. This is in accordance with Edström et al. (2008), whom describe an inherent problematic in SPHC where administrative tasks can take up too much time and resources from the actual care.

The operational unit portrays a high level of acceptance towards the PM, justified by its “good” purpose, and further claims to understand the bigger picture. In this regard, the PM is not perceived as incomplete and in terms of Jordan & Messner (2012), the purchaser gives sense to the PM in a way that is appreciated by the operational level. Nevertheless, from the operational unit’s perspective, the issues circle around the practical usage of the SIP. Claiming many of the practices emphasized by the SIP to already be in place, the acceptance of the additional administrative efforts demanded by management when using the PM is lower than what might have been the case if the PM in itself was perceived as more useful.

Drawing on Adler & Borys (1996), the purchaser and PC level perceive the PM as enabling the operational unit, aiding it in performing good care. However, although the operational unit recognizes the same rationale for and purpose of the SIP, it is nevertheless not considered as enabling. Further, Adler & Borys (1996) emphasize the need for control systems to be transparent when seeking to carry out enabling control. The transparency will facilitate an understanding both top-down and vice versa regarding the practical consequences of employing a certain PM. There is an absence of such transparency between top management and operational managers, which might explain the discrepancy between the higher hierarchical levels’ and the operational unit’s perceptions of the practical effects that the SIP entails. The operational level further attributes the lack of transparency to the inability to receive practical responses from decision makers at higher levels to issues raised at lower levels, which might be

attributed to the strictly hierarchical structure of the organization and the power asymmetry inherent in the BUM.

However, while exhibiting features of coercive control, as in the demotivating effect caused by the SIP on certain employees, the overall perception of the SIP on part of the operational unit is not that of a fully coercive PM or control system. It is continuously accentuated that there is an understanding of the reason for employing the SIP and it is primarily stressed that the only real issue is the lack of practical change that it entails. These circumstances considering the lack of transparency raise concern for the distribution of information. Jacobs et al. (2004) states the doctors and nurses within healthcare to be key decision-makers with a high level of power and autonomy, making their attitudes towards measurement essential for its eventual success. As discovered, the attitude towards the PM is not fully positive. However, as described by Landry & Knox (1996), an explanation of the unawareness at the purchaser and PC level regarding this attitude at the operational level of BUP X, might be found in the differences between clinical and administrative staff regarding e.g. accounting information.

The operational level is unaware of what the reported data is used for at higher levels, hence only able to account for its own individual case when discussing weaknesses of the PM. The purchaser is instead emphasizing a perceived effect on the topic of SIP when encompassing the whole region, including all BUP units. It's focus is on the matter of increasing the efforts for coordination between principals at the individual BUP units, thus not considering the attitudes at operational level towards the accounting system in itself, but merely the attitudes towards the purpose of and adherence to the SIP. This discrepancy leaves a gap in the transparency of the PM within the control system. Notable is that HSA acknowledges vagueness in the communication chain, although describing the vagueness in terms of operational units not understanding that funds are directed to them on behalf of the SIP. However, this is in turn not experienced as an issue by the operational unit.

One additional issue mentioned by all respondents is the lack of assessment of the effects of SIP, although stressing the complexity of assessing quality within PMHC and the recurring cases of patient with intertwined diseases as the main reasons therefore. This is in line with Donabedian (2005), whom describes the severe difficulties associated with measuring outcome and quality within PMHC. MG at HSA, purchaser level, is not aware of any specific target levels for the usage of SIP, and the PC level further attributes the lack of assessment of outcome effects to these nonexistent target levels. Both the HSA and the PC level merely claim the overall goal to be identification and reduction of the gap between patients being in need of a SIP and how many SIPs that coherently have been established. However, the operational manager recalls having been communicated a more specific target level, amounting to around 90 %, which A claims to be in accordance with other PMs' target levels. This target level has nevertheless been ignored due to the possibility of slack in performance if a target less than 100 % were to be communicated to the staff involved in the treatment. This has in turn led to the operational manager choosing to communicate that a SIP should be established for all the patients that are deemed to be in need of it; thus ending up in taking action in a coherent manner with the original idea of reducing the gap by striving towards always establishing a SIP when necessary.

Nevertheless, Hood (1991; 1995) underlines the assumption that within an effective organizational information system, information regarding performance and targets is provided to the right people. Further, Kurunmäki et al. (2003) and Goddard et al. (2000) emphasize the need to educate the clinicians in management accounting and providing them with information they need in order to the changing demands of measuring

performance. The non-existence of assessment amplifies the complexity of the PM since the lack of feed-back creates an additional space between purchaser and provider. This space can serve as an explanation as to why the perceptions of the operational units differ from that of the higher hierarchical levels since there is no communication of any effects of the usage of SIP, which could have reinforced the purpose of the SIP.

To conclude, the PM is perceived as neither enabling nor coercive. Whereas the purpose of the PM is appreciated in a similar fashion throughout the organization, the perceptions of the practical consequences it entails are differing. The operational level perceives the PM as being merely an additional administrative burden since the processes are already in place, whereas the purchaser and the PC levels perceive it as facilitating. Drawing on Adler & Borys (1996) and Jordan & Messner (2012), the lack of transparency and repair possibilities within the organization can help explain why the operational level's perceptions are not successfully communicated to other levels and the absence of discussions or assessments regarding the utility of the PM.

6 Conclusion

How is performance measurement being perceived at different hierarchical levels of a PMHC organization and what are the antecedents and consequences thereof?

Although there is an extensive amount of previous studies on the area of management accounting and performance measurement within the context of PHC, we have identified a gap in the research regarding how measuring performance can be perceived differently throughout a hierarchical chain of such an organization. Thus, as a contribution to the current literature, this study addresses this question by presenting the results from a case study performed in the context of a Swedish PMHC organization. By having analyzed certain underlying factors and consequences in the previous section, we will here finalize the thesis by presenting our conclusions from the key findings.

This case study has shown that PM can be perceived quite differently throughout an PMHC organization. The top level, here represented by the purchaser, was observed to generally strive towards simplicity as seen in the usage of the simplified productivity measure. Similarities were found in the formulation of the SIP, where the focus was on quality in terms of process and other aspects, such as outcome quality, were excluded. This perception was found to have a strong connection to previous research, where the usage of simplified measures has been identified to serve as facilitating for the top level to exert control at a distance. However, this view stands in contrast to the perceptions of the provider levels, which regarded the studied PMs as more or less incomplete in several aspects, and expressed a desire to have more complex tools for assessing their performance. The perception of incompleteness was primarily accentuated by the operational level and regarding the productivity PM. These observations were seen to have their roots in aspects such as the level of transparency and the perceived degree of reparability.

Transparency through hierarchical communication has been identified as crucial in order to identify discrepancies between the perceptions of different levels involved in the usage of a certain PM. In our case, the misconception of the purchaser as being the deciding force determining the structure of the productivity measure was based on the role assigned to this level by the operational unit, which was incongruent with the organizational reality. This misapprehension was found to exist due to the lack of transparency regarding the focal PM. Another striking finding was the differing views between the two provider levels, which contributes to underlining the need of transparency also internally in a provider organization. In our study this could be seen in the light of how the target levels of the SIP were viewed differently by the PC level and the operational level. Furthermore, lack of transparency and hierarchical communication may lead to an inability to address questions regarding the ability to repair an indicator deemed as incomplete and unfitting for the organization by the operational level. This was observed at BUP X where the management expressed both a need for alteration of the PM as well as willingness to cooperate in the process, although deeming the possibility of such an alteration taking place as impossible due to the absence of hierarchical communication, thus removing any perceived possibility to repair the indicator.

In addition, our research identifies that although the features of a PM are commonly understood throughout the hierarchical chain, this does not necessarily imply a high level of transparency. The comprehension of a PM throughout the user levels can stem

from the simplicity of the PM, which in turn is not an all-encompassing feature for enabling control. As found in the case of the productivity measure, the complex concept of productivity was perceived by the operational unit as in need of a more detailed PM than the one being in place. Thus, issues regarding incompleteness were found to arise when a controlled levels' willingness to account for certain activities was not taken into consideration by the owner of the PM. Regarding the productivity measure, issues of incompleteness were overshadowing other aspects that at first sight could be seen as positive e.g. what appear to be simple and beneficial terms to receive monetary compensation for the operational level. Additionally, such issues were identified as an antecedent to the application of alternative, informal PMs, confirming the findings of previous studies regarding such consequences.

Our research highlights that a PM does not need to be perceived as neither coercive nor enabling. Even when the purpose of a PM is commonly understood and appreciated throughout the hierarchical chain and used coherently at each level, this does *not* necessarily render the PM being perceived as enabling, as displayed in the case of the SIP. The enabling features of a PM may not be separable from the administrative praxis it entails, which in itself can be perceived as negative although the purpose of such a PM is welcomed. In the case of the SIP, the operational level regarded the activities that were sought to be implemented by the SIP as already being in place, making the additional administrative demands the only practical change accompanying the PM. At the BUP unit, this sometimes infused a demotivation to see patients since the amount of paperwork was somewhat immense, although the unit simultaneously stressed that it did not perceive the underlying purpose of the PM as negative.

This study underlines the necessity of transparency as being a key factor when employing a PM within an organization. As identified in the focal organization, a high level of transparency is necessary both regarding the intended purpose of a PM, as well as the roles assigned to each level as understood by all involved parties respectively. Without a commonly understood purpose, the discrepancy of the interpretations at each end of the hierarchical chain might lead to both an alteration of the use of the PM at lower levels and an entailing perception of the PM as being coercive, which can be seen in the case of the productivity measure. Furthermore, discrepancies between different organizational levels' role assignments, both to themselves, as well as others, can enhance the perception of a PM as being coercive due to a lack of understanding of the underlying reasons for its structure and use.

7 Summary

In order to study how PM is being perceived at different hierarchical levels of a PMHC organization, a case study was performed where empirical findings deriving from a scale of different purchaser and provider levels were compiled and consequently analyzed. The decision structure regarding two different PMs constituted the scope of the study: The productivity measure measuring the amount of patient visits per doctor and the SIP being a quality measure linked to the coordination of different processes.

When summarizing the productivity measure and the SIP, the most apparent issues highlighted by the study, mainly regarding the lack of both transparency and repair possibilities within the control system. Considering both PMs, there exists dissatisfaction with the current structures at the operational level, mainly accentuated regarding the productivity measure due to its perceived incompleteness and bad fit for BUP. Although the need for alteration is considered as more imminent in the case of the productivity measure, there is nevertheless an identified information gap between the purchaser and provider level regarding both PMs. This leads to the operational level perceiving the productivity PM as being coercive and, due to the lack of any practical effects of the implementation, the SIP as being neither enabling nor coercive.

In this case study, the inherent problem appears to be a result of the discrepancy between the roles that each hierarchical level assigns to both itself and the others, as is most distinguishable by how the operational level and the purchaser respectively regards the role of the purchaser and its involvement in the formulation of the PMs. The reasons therefore were identified as attributable to the absence of transparency and repair possibilities. The perception of the productivity measure as being incomplete was also observed to lead to alternate, internal usages of indicators in order to include certain factors of assessing productivity that were disregarded by the purchaser. To conclude, PM can be perceived differently at different hierarchical levels of the PMHC due to the ambiguous decision- and user structure and the hierarchical communication therein.

8 Recommended Further Research

Our study has identified several factors that have an effect on how PM is being perceived in a PMHC organization. Although the focus has been upon a *Mental* PHC organization, the main findings regard the relationship between the different hierarchical levels of the purchaser- provider model. As this relationship exists in several different forms in the Swedish PHC it would be interesting to see the results from a similar research in another, but similar context, e.g. investigating comprehensions of PM at different levels of the somatic PHC.

In order to try the findings derived from this study, additional investigations of the same nature regarding the perceptions of PMs within PMHC of other regions in Sweden could be undertaken. In addition, since our case study has focused on only one unit at the operational level, a study comparing the perceptions of given PMs on a horizontal scale would be suitable for further identification of key issues with PM in this context. Further, against the background that the productivity measure in our case was perceived as incomplete by the operational level, an investigation into the structure and perceived feasibility of productivity measures at other similar HC organizations could perhaps help shed some light on possible best practices and identify the general perception of what could better determine productivity within SPMHC.

The lack of outcome assessment regarding the implementation of the SIP implies another noteworthy area for further research; it would be interesting to follow the future results of this endeavor in order to identify potential consequences for the quality of the treatment derived from using this tool.

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Appendix: 1 - Interview Questions

The Productivity measure

How do you perceive measuring productivity/efficiency in general?

What do you perceive as the purpose with the productivity measure?

How do you perceive the productivity measure?

Do you experience any complexity with the productivity measure?

How is the communication regarding the productivity measure?

What does the decision structure look like?

The SIP

How do you perceive measuring qualitative aspects in PMHC in general?

What do you perceive as the purpose with the SIP?

How do you perceive the SIP?

Do you experience any complexity with the SIP?

How is the SIP perceived throughout the organization?

Is there any target level regarding the SIP?

Has any evaluation of the SIP been made?

How is the communication regarding the SIP?