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SCHOOL OF BUSINESS, ECONOMICS AND LAW

Balancing Conflicting Interests -
A Case Study of the Sahlgrenska University Hospital

Bachelor thesis in Business Administration
Spring semester 2011
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Acknowledgements

Numerous persons have been involved in and made it possible for us to write this thesis. We would like to express our gratitude towards our Mentor Peter Beusch who has helped us with his knowledge and critique during the entire process of writing this thesis.

The respondents also deserve to be acknowledged for their cooperation and time. Thank you.

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Gothenburg, 2011-05-30

Summary

Bachelor thesis in Business Administration, University of Gothenburg School of Business, Economics and Law, Spring 2011

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Title: Balancing Conflicting Interests – A Case Study of the Sahlgrenska University Hospital

Problem background: The Swedish health care system is experiencing increases in demand at the same time as funds and resources remains at a static level. Consequently, efficiency has become a vital part of hospital management and aims at maintaining the same level of quality and accessibility of healthcare services while minimising the use of resources. Hospital management is, however, made out of a strong medical profession and exposed to conflicting interests related to the process of improving efficiency. We have therefore chosen to study how the medical profession and conflicting interests affect the process of improving efficiency at a specific hospital, the Sahlgrenska University Hospital.

Aim of study: The aim of this thesis is to investigate how managers at the Sahlgrenska University Hospital handles conflicting interests that arise from the pressures of creating a more efficient organisation. Furthermore, we aim to study how the presence of the medical profession affects the process of creating better efficiency.

Limitations: Our thesis was conducted as a case study of the Sahlgrenska University Hospital. A significant drawback to the scientific credibility of the thesis is that only three clinic managers have been interviewed.

Method: The thesis has taken the form of a case study that has been conducted with a qualitative research approach. The empirical study consists of five personal interviews and has together with the theoretical framework been the basis for the analysis of the thesis.

Conclusion: The medical profession does not oppose the process of making the hospital more efficient as long it is beneficial to the individual patients. However, we have identified that the present management control system has failed to balance conflicting interests and those have become amplified through a focus on cost reduction. We have, therefore, recognised that a management control system that successfully achieves to balance conflicting interests is needed in order to create a sustainable hospital management and avoid opposition from the medical profession concerning the process of making the Sahlgrenska University Hospital more efficient.

Suggestions for further research: It would be of interest to do a more thorough study of how conflicting interests and the medical profession affect the process of making the Sahlgrenska University Hospital more efficient. Another point of interest would be to investigate how the balanced scorecard could be developed in order to achieve a balance of the existing conflicting interests.

Table of contents

1. Introduction 1
1.1 Background 1
1.2 Problem discussion 2
1.3 Problem definition 2
1.4 Aim of study 3
1.5 Limitations 3

2. Research Methodology 4
2.1 Research approach 4
2.2 Qualitative method 4
2.3 Secondary data 5
2.4 Primary data 6
2.4.1 Focus on clinic managers 6
2.4.2 Interviews 7
2.4.3 Respondents 7
2.5 Credibility 8

3. Frame of reference 10
3.1 New Public Management 10
3.2 Management control systems 11
3.2.1 The role of budgeting 11
3.2.2 The Balanced Scorecard 12
3.2.3 Quality Indicators in Healthcare Systems 14
3.3 The medical profession 15
3.3.1 Three different occupational groups 16
3.3.2 Medical professionals as clinic managers 16
3.4 Concepts of efficiency in hospital management 17

4. Empirical study 19
4.1 Hospital management at the Sahlgrenska University Hospital 19
4.2 The clinic managers 20
4.2.1 Place in the organisation 20
4.2.2 Level of control 20
4.2.3 Professional background 21
4.2.4 Accountabilities 21
4.2.5 Cooperation between clinics 22
4.3 Budgeting at the Sahlgrenska University Hospital 23
4.3.1 Setting the budget 23
4.3.2 The clinic managers role in the budget process 23
4.3.3 Budget control 24
4.3.4 Clinic managers view on budgeting 24
4.3.5 Budgeting and efficiency 25
4.4 The Balanced Scorecard at the Sahlgrenska University Hospital 26
4.4.1 Review 27
4.4.2 Clinic managers view on the Balanced Scorecard 27
4.5 Quality indicators at the Sahlgrenska University Hospital 28
4.6 The medical profession at the Sahlgrenska University Hospital 29
4.7 Conflicting interests at the Sahlgrenska University Hospital 30

5. Analysis **32**
5.1 The Budget process 32
5.1.2 Does the budget process lead to efficiency? *34*
5.2 The medical profession 35
5.3 Conflicting interests 36
6. Conclusions **39**
7. Suggestions for further research **41**
8. Bibliography **42**
8.1 Literature 42
8.2 Articles 43
8.3 Reports 44
8.4 Electronic sources 44
8.5 Verbal sources 45
8.5.1 The Sahlgrenska University Hospital *45*
8.5.2 Region Västra Götaland *45*
9. Appendix **46**
9.1 Appendix 1. 46
9.2 Appendix 2 47
9.3 Appendix 3 48
9.4 Appendix 4 49
9.4.1 Guide for interviews *49*

1. Introduction

Chapter one introduces the background of this thesis and presents the problem definitions through a problem discussion. This is followed by the aim of study and a description of the limitations of the thesis.

1.1 Background

Health is a basic part of human welfare and necessary for both economic and social development. Healthcare is, therefore, an indispensable part of any society and World Health Organisation (WHO) member states has agreed that everyone should be granted access to healthcare services. This leads to the immense importance of health financing which is one of the most important determinants for the accessibility of healthcare. (WHO, 2010)

Swedish healthcare is to a large extent financed through income taxes and the overall objective of the healthcare system is to ensure good health and provide equal health services for the whole population (Riksdagen, 1982). There is a rise in spending pressures, mainly because Sweden has a relatively old population with the largest proportion of people aged over 80 among the OECD-countries (Appendix 1). This has been the case for several years and still poses a serious threat in regards of fulfilling these objectives. There is little room for financing expansions of healthcare provisions through taxes and therefore the need to create a more efficient, that is the relation between inputs and outputs as well as health outcomes, hospital sector is apparent. (Rae, 2005)

The ability to combine the objectives of good and equal health with demands of efficiency is one of the biggest challenges in today's healthcare management. Because of the limited resources a focus on efficiency has become a vital part of upholding the healthcare system. This is illustrated in the Swedish law, Hälso- och sjukvårdslagen, that requires hospitals to provide a safe and high quality healthcare at the same time as it has to be efficient (Riksdagen, 1982), which at present time is as important as ever. Therefore, hospitals and managers need to have the ability to combine these interests, to balance them. (Hallin & Siverbo, 2003)

The Swedish government has launched an investigation with the purpose of making healthcare more efficient, which is due in spring 2012 (Borgström, 2011). This highlights that the present focus of healthcare management is efficiency and this is also the focus of this thesis.

This thesis is a case study of the Sahlgrenska University Hospital, the largest hospital in northern Europe. The hospital has about 16.400 employees and had a turnover of 12.3 billion SEK in 2010 and a positive financial result of 34 million SEK. During a normal 24-hour day at the hospital there are 2.200 doctors appointments, 500 emergency visits, 30 childbirths and 18.500 lab analyses conducted. In addition, the hospital has recently managed to reverse a

negative trend with several years of budget deficits and has now had two years in a row with positive results in the income statement, which makes it an interesting object to study. (Sahlgrenska Universitetssjukhus, 2011)

1.2 Problem discussion

The income of the Sahlgrenska University Hospital is mainly fixed and determined on an annual basis, thus the hospital cannot affect its income depending on its performance. In order for Sahlgrenska to be able to meet a higher demand for healthcare services, when it is subjected to limited resources, it has to strive towards becoming a more efficient organisation. Consequently, efficiency is a vital mean for achieving better accessibility and quality of healthcare services while attaining a balanced economy.

The majority of managers at subordinate level in the hospital are medical professionals[1] and the values and beliefs of these professionals generate a loyalty towards the patients and their own profession rather than towards the organisation and its management. This is most certainly one problem that the clinic managers (verksamhetschef in Swedish) have to take under consideration. These are the managers that are in contact with the daily operations and responsible for the financial results and the quality of the services provided by their clinic. The objectives and priorities of politicians, administrators and the medical professionals often differ and may cause disruptions. All of this makes an efficient management difficult to achieve and the risk of resistance and on occasion revolts from medical professionals that arise from conflicting interests is a pressing issue (Eliasson, 2011). Nevertheless, in order for healthcare to function and offer the necessary healthcare services it has to manage its resources efficiently. This means that a hospital has to have the ability to manage conflicting interests related to efficiency. (Hallin & Siverbo, 2003)

1.3 Problem definition

- How do conflicting interests in hospital management and the medical profession affect the process of making the Sahlgrenska University Hospital more efficient?

- How has the clinic managers' economic awareness and attitude towards efficiency developed over time at Sahlgrenska University Hospital?

[1] In this thesis defined as the group of people in a hospital who possess a degree in medicine and authority based on medical expertise, most notably doctors and nurses.

1.4 Aim of study

The aim of this thesis is to investigate how the clinic managers at the Sahlgrenska University Hospital handles conflicting interests that arise from the pressures of creating a more efficient organisation. Furthermore, we aim to study how the presence of the medical profession affect the process of creating better efficiency and in particular regarding managers of medical background.

1.5 Limitations

This thesis will take the form of a case study of the Sahlgrenska University Hospital and no other organisation. We will not make a comparative study between different hospitals but will focus on the management of the Sahlgrenska University Hospital.

Within the organisation of the hospital we will primarily look at the role of clinic managers who are accountable for the financial results and the quality of health care services of their respective clinics. The selection of which clinics that has been included in the study has been based on size but also to a large extent the clinic managers' willingness to participate in personal interviews. Thus, the thesis has not focused on only one clinic but several and it is the clinic managers that have been approached. A significant limitation of our study is that only three clinic managers has been interviewed, which will be discussed further in the research methodology.

Another limitation that is important to take under consideration is that only medical professionals and administrators have been approached in our research and no politicians. The politicians do have considerable influence over the organisation, however, the perspective of politicians is not included in this thesis. The clinic managers are both administrators and medical professionals and thereby represent two different categories of professionals. However, medical professionals who do not have a managerial position have not been interviewed.

2. Research Methodology

This chapter describes how the thesis was conducted. The research approach is described and how secondary and primary data was collected. Furthermore, a thorough description of how the interviews were conducted is presented and this is followed by an assessment of the credibility of the thesis.

2.1 Research approach

This thesis is a qualitative case study of the Sahlgrenska University Hospital, investigating how conflicting interests and the medical profession affect the process of making the hospital more efficient, primarily from a clinic manager´s perspective.

The thesis is based on a descriptive research problem, as the intention is to describe and analyse the situation at the Sahlgrenska University Hospital with the help of already existing theories and the empirical study (Patel & Davidsson, 2003). The theoretical framework is based on well-established theories that are relevant in order for one to understand and analyse the empirical findings. Literature and theories have been studied continuously during the study with a wide selection in the beginning and narrower at the end. The empirical study is based on personal interviews and these interviews are supposed to provide us with a deeper understanding of the respondents´ view on efficiency, conflicting interests, the medical profession and how this affect them in their work. In the analysis we relate the empirical findings to the theoretical framework and try to identify important deviations. The analysis culminates in a conclusion that more concretely answers our stated problems.

Hence, the research approach of this thesis has taken the form of being a combination of the deductive and inductive method, and could, thereby, be labelled as an abductive study (Patel & Davidsson, 2003). More specifically, we have started out from reading more or less established theories and, thereafter, made an empirical study in the form of a case study based on interviews. The theoretical framework and empirical study have subsequently been used in order to make an analysis and draw conclusions out of the stated problems of this thesis.

To summarize, this thesis is a case study of the Sahlgrenska University Hospital where a qualitative method has been chosen in order for us to get a deeper understanding of the situation at the hospital, information has been gathered through both secondary and primary data and this data are analysed and finally thoroughly explained in the conclusions.

2.2 Qualitative method

A qualitative research approach is the most suitable for this thesis, since the aim is to deeply study the situation at the Sahlgrenska University hospital, with a focus on clinic managers. The method allows a closer contact to the object of the study, in this case the respondents, and this will provide a better and deeper understanding of their situation and views. A qualitative method is also suitable because it enables more flexibility rather than a strict structure as in

the quantitative method. Since the focus in our empirical study is to identify the views of the respondents, which can be seen as more soft values, and we need to be able to adapt the questions to the answers given is the obvious choice to use a qualitative method. (Holme & Krohn Solvang, 2006)

2.3 Secondary data

Secondary data is data that is retrieved from an already existing source, for example from publications and textbooks (Patel & Davidsson, 2003). The theoretical framework is based on secondary data and it was gathered with the purpose to provide the information needed to understand and analyse the information retrieved in the empirical study, with a perspective on efficiency, the medical profession and conflicting interests. The secondary data used in the theory has been found mainly via the services provided by the Gothenburg University Library. However, we have also been able to find relevant information via the official website of the Sahlgrenska University Hospital and other public organisations related to the healthcare system in Sweden such as the National Board of Health and Welfare (Socialstyrelsen). Some of this secondary data, from the hospital, has also been used in the empirical study with the purpose to portray the organisation and management of the hospital.

Articles and reports were gathered from larger databases provided by the library such as Business Source Premier, Google scholar, LIBRIS, GUNDA and GUPEA. These articles, reports and dissertations were collected with the purpose of providing the theory needed in order to answer our stated problems. Examples of keywords used in the searches are “New Public Management”, “public management”, “medical profession” and “efficiency + hospitals”. Articles and reports from international organisations such as WHO and OECD have also been used for the theoretical framework, these have either been retrieved from their official websites or from the databases provided by the library. We have also used textbooks and other printed sources for the frame of reference, which we borrowed from the university library.

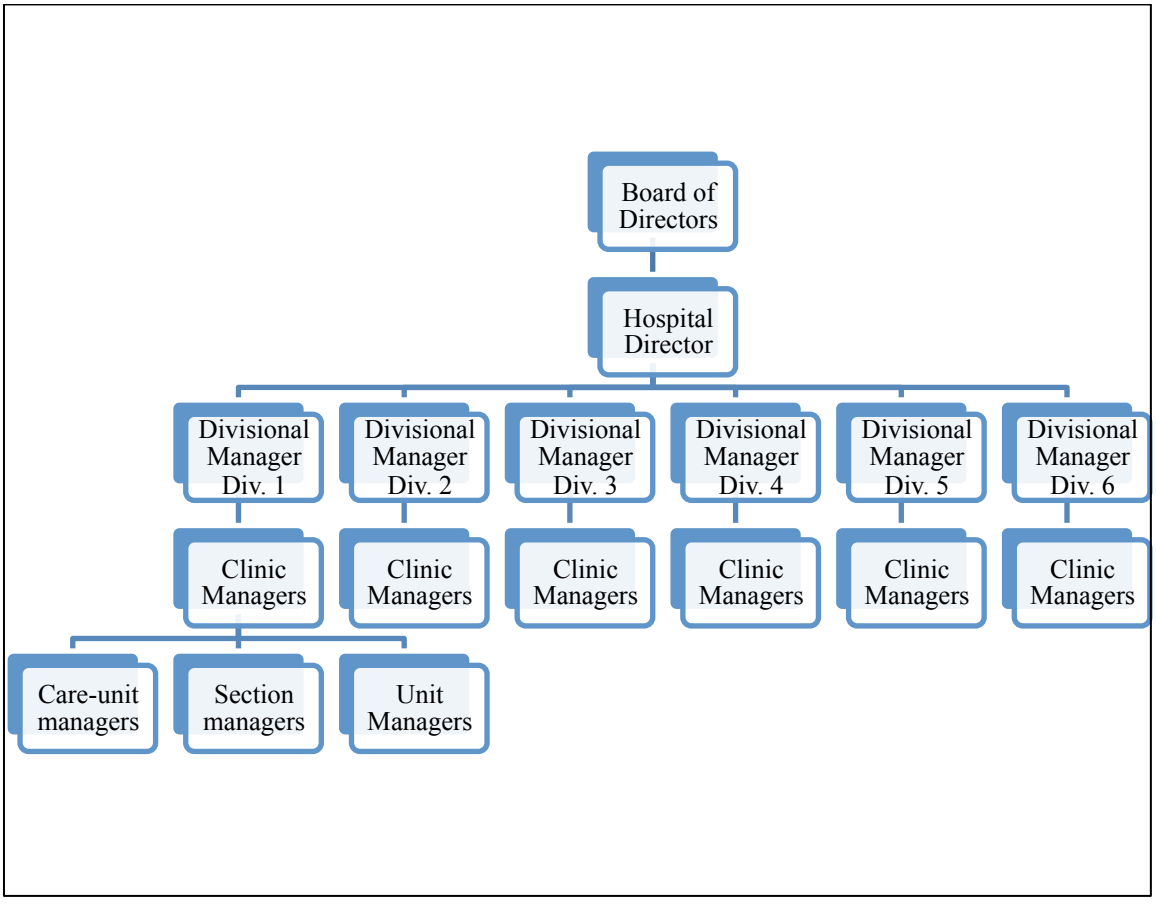
The majority of the sources that have been used in the thesis have been released recently and we consider all of them to be of current interest. More importantly, however, we have evaluated the relevance and appropriateness of the sources in relation to our thesis. Attention has also been given to the degree of subjectivity or objectivity of the sources in order to ensure a high degree of reliability. Most of the sources used are scientific reports or books written by academics that have been scrutinised and approved of by other researchers and academics and we consider them to be objective. We also consider sources that are of the subjective kind to be of benefit to our research but are aware of the importance of questioning the objectives and reliability of them.

2.4 Primary data

Primary data is first hand information that is gathered straight from the original source (Patel & Davidsson, 2003). The primary data, for the empirical study, was collected in the form of five personal interviews with employees at the Sahlgrenska University Hospital. These interviews were conducted with the purpose of providing us with a deeper understanding of the situation at the Sahlgrenska University Hospital.

2.4.1 Focus on clinic managers

The managerial structure at the Sahlgrenska University Hospital is built around four management levels. At the highest level is the hospital director followed by the divisional managers of each of the six divisions within the organisation. In turn, these six divisions are made out of a varied number of clinics that are lead by the clinic managers. At the lowest level of management are the care-unit managers, section managers and unit managers who answers directly to the clinic managers. The care-unit managers are responsible for the nursing activities, the section managers for specific specialist groups within a clinic and the unit managers are the heads of various administrative personnel. In other words, in terms of the managerial level in the organisation the clinic managers are placed in the middle and this is the managerial level that will be the focus in this thesis.



Source: Appendix 2 (Sahlgrenska Universitetssjukhus, 2011)

2.4.2 Interviews

In order for us to get a picture of the managers´ perception and point of view on the management at the Sahlgrenska University Hospital we conducted five individual semi-standardised qualitative interviews. Semi-standardised interviews are best suited for the empirical study, since we can adapt our questions to the answers given by the respondent and this will lead to a more coherent and meaningful discussion. This means that we have prepared questions for the interviews but we are not entirely locked by these, if we need to we can diverge from our prepared questions to find out more about an idea or response. This reduces the risk of missing important information and gives us a greater possibility to get the answers that we need to make an analysis. (Patel & Davidsson, 2003)

2.4.3 Respondents

The majority of the interviews were conducted with clinic managers and this was evident since the focus of the thesis lies on the clinic managerial level. These managers are in close contact with the daily operations and are responsible for the efficiency and the quality of their clinic. The purpose of these interviews was to clarify these managers´ views of efficiency and the problems related to that. One factor that has been relevant in the selection of which clinic managers to interview was to get clinic managers from various sized clinics. The purpose of this was to investigate if there are any differences in responses depending on the complexity and size of clinics.

Position	Date	Duration	Type of Interview
Clinic Manager	2011-04-18	90 Minutes	Personal Semi Standardised Interview
Head of development Region Västra Götaland	2011-04-21	60 Minutes	Personal Semi Standardised Interview
Clinic Manager	2011-04-29	60 Minutes	Personal Semi Standardised Interview
Hospital Director	2011-05-09	60 Minutes	Personal Semi Standardised Interview
Clinic Manager	2011-05-11	60 Minutes	Personal Semi Standardised Interview

Furthermore, in order for us to get a more complete perspective on Sahlgrenska´s and the clinic manager´s activities and management control systems, interviews were also conducted with the hospital director and a head of a unit working with development. The hospital director has the overall responsibility of the hospital and is in contact with all stakeholders (politicians, administrators and the medical professionals) involved in the hospital management. Thus, the purpose of these interviews has been to give us a greater understanding of how the clinic managers attitudes and economic awareness has developed over time from their perspective and to give us a greater understanding of efficiency problems at Sahlgrenska University Hospital.

The first interview was conducted relatively early in the process of writing this thesis and the purpose of this was to confirm the relevance of our topic and our stated problems. Another reason for this early interview was to give us a clearer picture of the structure of Sahlgrenska and how the daily activities are characterised for a clinic manager and to what extent they actively work with efficiency.

2.5 Credibility

To assess the credibility of the qualitative research in this thesis we need to know that what we are studying is what we are meant to study, which determines the degree of validity. In turn, we also need to know that the research is conducted in a reliable manner. (Patel & Davidsson, 2003)

To ensure that the thesis holds a high level of validity the aim of study and the problem definitions have been continuously discussed and reviewed. These have also been central in the process of collecting both secondary and primary data that have been used in the theoretical framework and empirical study. Since the empirical study is based on personal interviews it is inevitably subject to some degree of subjectivity. To maintain a high level of validity we have used a semi-standardised question template for the purpose of minimising distortions from prior interviews. In other words, the same key questions have been asked to all respondents but we have not made any limitations regarding posing follow-up questions. Moreover, interviews have been recorded and transcribed as long as this has been permitted by the respondents, with the intent of not missing vital information and avoid bias from preconceptions. It also gives us a better opportunity to focus on the interview, take in what is being said and think of follow-up questions during the course of the interview.

A significant drawback to the reliability of our thesis is that we have only interviewed three clinic managers even though those are the focus of our research. These are too few to represent the hospital and all of the clinic managers. This is a serious flaw that means that we cannot make reliable general assumptions or conclusions. Each of the three clinic managers has been given substantial space in the empirical study, which has a negative effect on the reliability of it. As the personal interviews are affected by subjectivity, they may have a negative impact for the reliability of the thesis and especially considering that each clinic

manager are given considerable space. Nevertheless, as we have continuously taken into consideration that it is the conceptions and personal views of respondents and not the truth or reality that are being portrayed, we believe that the study still holds a sufficient level of reliability. We find that the results from our interviews are of great interest and that the study, nonetheless, gives a depiction of the work of clinic managers at the hospital that holds value.

3. Frame of reference

Chapter 3 starts by introducing New Public Management, which is followed by a description of Management Control Systems, including the Budget, the Balanced Scorecard and Quality Indicators. The medical profession is described as well as the different occupational groups in hospital management and an assessment of what being a medical professional implies for clinic managers. Finally, the concepts of efficiency in hospital management are addressed.

3.1 New Public Management

Since the end of the 1980s, rationalisation and restructuring efforts have virtually touched all forms of activities in the public sector, from the public school system and the military to the public healthcare system. New public management refers to the collection of management and leadership practises that have been introduced in the public sector since the 1980s with the purpose of making the state´s finances more balanced. Hence, it is a broad term for several different management ideas where many philosophies are borrowed from the private sector. One could say that New Public Management is the collective name for concrete reforms in the public sector that mimics the functioning and thinking patterns that are common in the private sector. (Hasselbladh, Bejerot, & Gustavsson, 2008 and Almqvist, 2004)

Professor Christopher Hood summarises the typical features of New Public Management in the form of seven components (Hasselbladh, Bejerot, & Gustavsson, 2008):

- Introduction of decentralised profit or cost responsibility, which divides former, unified public bodies into smaller organisational units.
- Internal markets, units "buy" and "sell" their services to other units or purchasers.
- Cost-awareness, constant rationalisation of the operations and organisation in order to make the business more cost-efficient.
- Extended application of methods and models from the private market in everything from personnel and wage policies to models of controlling the entire operation.
- Greater formal freedom of action and clearer responsibilities for managers at different levels.
- Efficiency is assessed in relation to explicit and measurable goals.
- Focus on customers and financial results.

The researcher Karina Sehested writes in an article (2002), "New Public Management reforms are often based on the criticism of the large professionalised bureaucracies out of control for managers and politicians". What she means is that the reforms are often made in order to decrease the domination and power of professionals in public organisations, in this case health care. The autonomous professionals are perceived as motivated by self-interest and will only fight for more resources in their area to increase their status and prestige. She writes that trust in professionals and professional bureaucracies is replaced by mistrust and privatisation and various audit mechanisms are introduced as necessary. Subordination, hierarchy and control as a governing principle have to replace the governing principle of professional norms and

values. Hence, a motive for introducing these New Public Management reforms is to strengthen the power of administrators and politicians in order to achieve some sort of balance of the power and thereby making the organisation easier to manage and control. (Sehested, 2002)

3.2 Management control systems

Through the development of New Public Management, public organisations have become more result oriented and control systems are now an essential part of management. As organisations have become increasingly decentralised, results controls are being used more frequently as a mean of controlling the behaviour of employees at different organisational levels (Almqvist, 2004). This is in particular true for organisations that consist of professional employees and where managers have a responsibility for achieving results rather than plainly performing tasks. (Merchant & Van der Stede, 2007)

In decentralised organisations where employees are confided with a high degree of autonomy, result controls offer a way to inform what results are expected and to motivate employees to do their best to achieve these results. However, in order for the implementation of results controls to be effective, there are certain conditions that have to be fulfilled. First, organisations need to know what results that are desired and be able to communicate these to managers responsible for autonomous units. Second, the managers and employees that are held accountable for achieving the desired results must be given the ability, and authority, to influence these. Third, for results controls to work organisations need to have the ability to measure the results effectively. (Merchant & Van der Stede, 2007)

3.2.1 The role of budgeting

In Sweden major reforms were undertaken concerning the institutional framework and process governing government expenditure in the 1990s. As a part of the reforms, the budget process in the Swedish healthcare system was instituted as a top-down form of control with ceilings for total expenditure. Since then, the budget has had a central part in the management of hospitals. (Roseveare, 2002)

Budgeting is an important aspect of both financial and non-financial results control systems and are primarily used for planning and as a basis for allocating scarce human, physical and financial resources (Fischer, Maines, Peffer, & Sprinkle, 2002). The budget clarifies which goals that serve the organisation's interest, how to achieve them and what results that can be expected from managers. The planning process of a budget is in itself an essential management tool that serves to make managers think about the future and share their ideas across the organisation and get motivated to achieve the goals that serve the organisation's interests. (Merchant & Van der Stede, 2007)

Planning and budgeting systems often differ significantly across different organisations, especially considering public and private actors. However, the purposes of the planning and

budgeting systems are in large the same regardless of the setting and are often summarised in four main characteristics. First of all, planning serves as a way to force or motivate employees and managers to think strategically and long-term as well as a mean of creating a better internal understanding of an organisations strengths and weaknesses. Secondly, budgeting serves the purpose of coordinating the organisation and encourages communication and cooperation across the different managerial levels. Top management informs about the priorities and goals of the organisation while bottom-up communication makes sure that the top management is aware of the opportunities, constraints, resource needs and risks that has been identified in lower levels of the organisation. The third purpose of budgeting is to create top management oversight of the organisation. This is an oversight that is most commonly a result of preaction reviews in which plans are examined, discussed and approved or disapproved. This leads to the motivational effect of planning and budgeting, which is the fourth purpose budgets. Through the planning and budgeting processes top management gets a good idea of what performance targets are realistic and achievable by negotiating with lower-level management. This will increase the motivation of managers as they are involved in the setting of performance targets that should lead to targets that are challenging but possible to achieve. (Merchant & Van der Stede, 2007)

Aron Wildavsky (1975) wrote that the budget process also consist of a bargaining game between two different roles, advocates and guardians. Simply put, the advocates are close to the daily operations and the customers and are mainly interested in their own activities and are trying to usurp as much resources as possible. The guardians, often administrative personnel and managers, have a broader perspective and want to ensure that the resource consumption will be held to a minimum. (Wildavsky, 1975)

3.2.2 The Balanced Scorecard

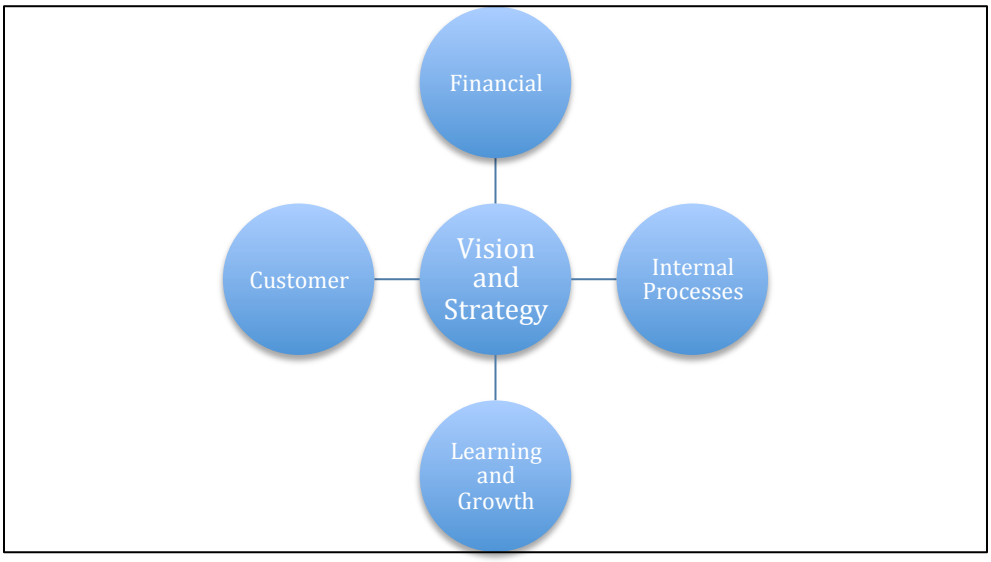
All organisations must perform well financially in order to function successfully. This is most certainly the case for private companies that are characterised as having ambitious plans for growth and high financial profits but also for public and non-profit organisations who need to make the most out of the, often scarce, funds and resources that they receive. The importance of managing organisations well in regards to achieving satisfactory financial performances is therefore central. A pure financial approach of going about this issue is, however, not necessarily the best method. With regards to this, Robert Kaplan and David Norton introduced a performance management system with a strategic approach that is known as the Balanced Scorecard method. Seeing that the gap between performance ambition and results in most companies was large, they developed the Balanced Scorecard in order to create a better connection between companies strategy formulation and strategy execution. (Kaplan & Norton, 2005)

The Balanced Scorecard has been developed with an apparent focus on the private sector and with performance measurement that are appropriate in that context. According to an expert on the Balanced Scorecard, Niven (2003), public and non-profit organisations should therefore consider changing the model to fit their particular strategy and circumstance. Public

organisations, such as hospitals, need to adapt their Balanced Scorecard so that it looks beyond the inputs and outputs of the organisation. What this infers is that the Balanced Scorecard needs to address a broader performance perspective out of the organisations true mission, such as measuring if patients are better off from the results of the efforts in a hospital. Because public organisations can be characterised as serving a higher purpose than achieving financial success the other perspectives of the Balanced Scorecard are vital for the possibility to measure the degree of achievement of that purpose. Public organisations need to be held accountable for an efficient use of funds and resources but unlike private actors they are responsible for serving customers and not stakeholders. The logical step for public organisations is therefore to put the Customer perspective as the priority and not the Financial perspective as it is the most relevant performance measurement in regards to their mission. It is, however, important to note that an efficient use of funds and resources is necessary to achieve customer success. The perspectives of Internal processes and Learning and Growth should, thereby, be developed in such a manner that it serves to create an organisation that excels in order to create value for customers. The Balanced Scorecard should focus on the processes that lead to better outcomes for customers and allow the organisations to work towards its mission. (Niven, 2003)

The Balanced Scorecard offers top-management the possibility of creating an understandable framework that translates an organisations strategy and objectives into an articulate set of performance measures. The Balanced Scorecard looks at four perspectives, represented in Figure 1, that break down key performance targets that should be integrated and easy for lower-level managers to interpret. (12manage, 2011)

Figure 1: The four perspectives of the Balanced Scorecard



3.2.3 Quality Indicators in Healthcare Systems

One of the most central forms of results controls of hospital management concerns the quality of healthcare services. The OECD has developed a set of indicators that look at the quality of healthcare for key conditions and treatments with the intention of creating a way to make comparisons across countries. The quality indicators put specific focus on the efficiency in which the healthcare services is carried out, which is seen as an integral part of the actual quality. They are to be used as the basis for investigating why differences exist and what can be done to reduce those differences and in the end improve the quality and efficiency of healthcare services. (Mattke, Kelley, Scherer, Hurst, & Lapetra, 2006)

In the Swedish healthcare system the use of quality indicators is a key part of management control systems and an extensive comparison between hospitals is undertaken each year, covering a wide range of conditions and treatments. The use of quality indicators is an established way of measuring results in hospital management and a vital form of results controls in which managers at different managerial levels in hospitals are held accountable for the quality and efficiency of the healthcare services that they are in charge of. Each year, a report comparing the quality and efficiency of healthcare services between Swedish hospitals is published. The purpose of this report is to make a contribution to the leadership and management of healthcare systems and to establish a basis for evaluation and a way to allocate accountability for results. Another important purpose of the report has been the ambition to contribute to an improvement of data collection of results and performances related to the quality and efficiency in hospitals. This is seen as an important step towards a better ability to measure results more effectively. (Sveriges Kommuner och Landsting och Socialstyrelsen, 2010)

3.3 The medical profession

The whole healthcare system and foremost hospitals can be considered as a knowledge- based organisations. The central assets in these organisations are the human capital and the competence of the employees. Some characteristics of a knowledge-based organisation are a high level of education and a high degree of professionalisation amongst the majority of the employees, the daily work contains essential elements of problem solving and a non-standardised production and a high autonomy of the practitioner. (Alvesson, 1992)

In a hospital, professional and semi professional occupational groups dominate the activities. Nurses are examples of the semi-professional group and doctors and psychologists are example of the professional group. Ernest Greenwood (1957) cited five basic attributes of a profession (Hallin & Siverbo, 2003):

- Systematic theory, theories are developed systematically based on the area of expertise of the profession.
- Authority, based on expertise, the professionals have the right to express themselves with authority.
- Community sanction, society should find it important that the profession exists.
- Ethical codes, the professionals possess some specific and common ethical views concerning the profession´s activities.
- A common culture, the professionals have norms and social values, which make up a common culture.

The medical profession (doctors) is one of the world´s oldest professions and it is very much characterised by these attributes mentioned above (Öfverström, 2008). The medical knowledge can be seen as the main asset in a hospital and therefore the doctors, who possess this know-how, get a strong position. They have a knowledge-advantage over their environment, their patients and other personnel at a hospital. This includes the politicians and administrative management, who depend on this knowledge in order to control and develop the organisation. The knowledge-advantage and a strong loyalty among the doctors are important factors when considering that the doctors have developed a strong independence or autonomy in their profession. The doctors enjoy great clinic freedom and their work is primarily controlled by themselves and the colleagues within the profession. This means that for example quality issues are primarily a matter for the individual doctor and his or her colleagues. (Hallin & Siverbo, 2003)

In Swedish hospital management, medical activities are dominated by the values of the doctors and the basic ideology among the doctors is primarily derived from the Medical Association´s code of ethics. According to these ethical values a doctor should have the patients wellbeing as its main goal to pursue and be led by humanity and honour (Sveriges läkarförbund, 2002). Hence, the individual patient should be the focus of the doctor´s work and it is the doctor´s responsibility to ensure that the patients get the best care possible. For a doctor, the quality of care and the enforcement of the professional standards within their own

speciality is the main target when measuring success in his or her work. The values and beliefs of the doctors generate a loyalty towards the patients and their own profession rather than towards the organisation and it´s management and resource scarcity is often perceived as a threat to the medical quality and clinic freedom. (Hallin & Siverbo, 2003)

3.3.1 Three different occupational groups

There are three different players in hospital management who all have different views and approaches towards health care: politicians, the administrative management and the medical profession. Each player has their own principles and logic of actions and they derive their thinking from their norms and values, which means that the organisation often becomes a process marked by different desires and conflicts. (Östergren & Sahlin-Andersson, 1998)

3.3.2 Medical professionals as clinic managers

The medical profession, in this passage referring to doctors, is a homogenous group but within the group there is a strong hierarchical structure based on status. The status of doctors depends on the length and quality of their education, their skills, which speciality they belong to and where their workplace is located. For example, surgery is a speciality with a high level of status while geriatrics and family care is associated with a low level of status and working at a university hospital is considered much better than working in an ordinary hospital or in primary care. Moreover, having achieved a disputation is considered as very important and is often necessary for doctors with ambitions of becoming a manager. This hierarchical structure based on status has a significant impact on the function of hospital management, which can be characterised a highly competitive one. Most notably, the different groups within the medical profession compete over resources, prestige and influence in the organisation, making it hard to control. (Hallin & Siverbo, 2003)

What this entails for medical professionals who decide to take on the role of managers is a position stuck between being a professional and an administrator. Being a manager in a hospital does not necessarily lead to a higher status in the eyes of the medical professionals, rather the status is based on the extent to which the manager has been successful in the latter's professional carrier. The role of clinic managers can be described as a mediator between the medical profession and the managerial leaders of the hospital whom have a relationship that is characterised as having inherent competitive conflicts. For example, from the top-management the clinic managers are given the responsibility to balance the budget, which may involve actions such as downsizing and cutting down on resources. At the same time, the medical professionals regard cuts as counterproductive and, therefore, question the clinic managers and their loyalty. In other words, being a clinic manager means putting yourself in a difficult position between professionals and upper-management. (Öfverström, 2008)

3.4 Concepts of efficiency in hospital management

Efficiency is one of the most central conceptions in business administration and before looking into what efficiency means for hospital management there is a point in describing the general definition of the term. The efficiency of an organisation is said to be the relationship between the value of what has been achieved and the value of the resources and performances necessary to reach this specific achievement. In other words, the efficiency could be said to be the degree to which an organisation reaches its goals. (Ax, Johansson, & Kullvén)

Defining what is meant by efficiency related to hospital management is associated with considerable confusion and may in some aspects differ from definitions in general. Assessing and measuring efficiency in hospital management means putting certain resource inputs in relation to outputs and the final outcomes of healthcare services. The kind of inputs such as labour, capital and equipment used do not differ substantially from any other organisation and often involve the number of physicians, time used for surgical operations and number of technical units. The most typical outputs related to hospital management are the number of patients treated and discharged and waiting time. The question that causes the most confusion is how to determine what final outcomes that are relevant and appropriate to measure. Some would argue that better health and equality in access should be the sought outcomes while others regard fairness in financial contribution and responsiveness to people's expectations just as important. (the European Commission and the Economic Policy Committee, 2010)

Most commonly, efficiency in hospital management is measured as the relationship between inputs (labour, capital and equipment) and outputs (number of consultations or hospital discharges) and not health outcome. This relationship is fairly easy to measure once the combinations of inputs that are used in order to realize a specific output have been determined, which on the other hand is subject to complications. However, outputs are often poor determinants for the impact of medical treatments on health. Efficiency could therefore be redefined as the relationship between inputs and health outcome such as lives saved or longer lives and, thus, become a more relevant measure for the goal of providing people with healthcare services that results in better health. As an example, efficiency could in this case be defined as the maximum number of saved lives or number of additional years of life attained while minimising resource usage. In practice, efficiency analysis is often based on both outputs and health outcomes depending on data availability, however, measuring health outcomes is regarded as more complex and less reliable. (the European Commission and the Economic Policy Committee, 2010)

Efficiency measures in hospital management can be assessed in three different ways: system wide, sub-sector of care and by disease. The system wide approach focus on population health status as the outcome and often use inputs such as total spending. The main advantage of this type of efficiency measurement is that data availability is high and therefore the method is widely used to make comparisons between healthcare systems internationally. The sub-sector approach is the one that often come into play when studies related to efficiency in hospitals are conducted. This approach focuses on the gains brought specifically by hospitals or individual divisions in a hospital and is therefore used when making comparisons between

hospitals at domestic level. However, the approach has a significant drawback in that it primarily looks at output-related efficiency measures. The disease-level approach attempts to measure the cost-efficiency of medical treatments for specific kinds of diseases. As it focuses on the gains in health form different kinds of treatments the approach is held as very attractive, however, due to lack of data it is hard to implement and to use comparatively. (OECD, 2010)

4. Empirical study

This chapter starts by giving an overview of the Sahlgrenska University Hospital and the guidelines that lay the basis for how the hospital is managed. Thereafter, the role of clinic managers is clarified by describing their place in the organisation, level of control, background and accountabilities. The management control system at the hospital is explained, which includes the budget process, balanced scorecard and quality indicators as a basis for comparisons. This is followed by a description of the medical professionals with a focus on how their awareness and perception of efficiency has developed. Finally, the conflicting interests that clinic managers face in their work are illustrated.

4.1 Hospital management at the Sahlgrenska University Hospital

The Sahlgrenska University Hospital was founded in 1997 through a merger of the hospitals Sahlgrenska, Östra and Mölndal. The hospital is a part of the Region of Västra Götaland, which is where the board of directors that purchase the healthcare services of the Sahlgrenska University Hospital is based. The hospital provides emergency and basic care for the Göteborg region, 700 000 inhabitants, and specialised care for West Sweden, 1.7 million inhabitants. (Sahlgrenska Universitetssjukhus, 2010)

The Region Västra Götaland's budget 2011 outlines the guiding principles that the hospital management in the region is based on and that the Sahlgrenska University Hospital is obliged to follow. In reference to the budget, the basic principles that the hospital management should be based on are that healthcare services are to be patient-centered, knowledge based, efficient, equitable and provided in a timely manner. The budget also declares that the management control systems should be focused on the quality of healthcare services and patient safety as well as ensuring an efficient use of resources. One of the top priorities concerning the hospital management is shortening the waiting times but the budget also underlines the importance of discarding medicals, methods and equipment that are ineffective or are of little or none value to the patients. Moreover, all levels of management in the organisation should develop management control systems that systematically work with goals, taking measures, accountability and evaluation. It is also stated that the hospital management has to provide functioning cooperation between the different clinics of the organisation, which is described as a key factor in reaching the goals of the organisation. (Västra Götalands Regionen, 2010)

Regarding the economic outline the overall objectives are that each managerial unit should have a balanced economy and continuously work on improving the efficiency. The financial focus is to achieve a stable economy that is characterised by sustainability and the importance of economic strength is emphasised in that it is needed for future possibilities to take action. A central part of the management is therefore creating a high level of equity so that it can carry out the necessary activities without increases in the regional tax rate or downsizing of the organisation. In other words, it is stressed that the development of healthcare services and actions for shortened waiting times and improved accessibility must be upheld even in economically difficult periods. However, the budget recognises that, as of now, there is little

chance of improving the equity as most of it has to be used in order to fund expansions and new investments. As a result, emphasis is given to the need of working on efficiency, which, according to the budget, has to be aligned with cost controls, a balanced budget and improved quality of healthcare services. The responsibility of implementing demands of improved efficiency lies upon the divisional and clinic managers who are held accountable for their respective units performance. (Västra Götalands Regionen, 2010)

4.2 The clinic managers

4.2.1 Place in the organisation

As portrayed in the organisational chart in section 2.4.1, the Sahlgrenska University Hospital is lead by the board of directors and the hospital director. The board of directors is formed by nine political members whom the hospital director answers to. The managerial body of the hospital is constituted by the hospital director and the heads of each of six divisions within the hospital. These are responsible for attending to and making decisions regarding long-term and principal matters related to the hospital management, however, it is the hospital director alone that has the decision mandate. Under each of the heads of divisions are the clinic managers who have the operational responsibility for the quality, efficiency and financial results of the hospital clinics. At the lowest level of management are the care-unit managers, section managers and unit managers who answers directly to the clinic managers. (Sahlgrenska Universitetssjukhus, 2011)

4.2.2 Level of control

The management control system at the Sahlgrenska University hospital is to a large extent based on top-down management. As one clinic manager describes it, the hospital director is given a fixed amount of money by the board of directors that has to be distributed to the divisions and clinics and it is entirely up to him and the divisional managers to decide how this is to be done. The clinic managers are not involved in this process and do not have any opportunity to share their knowledge concerning constraints, needed resources and reasonable performance targets. In other words, in terms of bottom-up management the clinic managers have a very low level of authority and practically none in the process of allocating resources or setting performance targets.

The operational management of the clinics is, however, more or less entirely in the control of the clinic managers. They have the authority to decide how the clinics are to be run in order to reach the performance targets that are given to them. There are no clarified guiding principles of how a clinic manager should manage their respective clinics, instead they are given the authority to make decisions themselves. More specifically, they have the authority to downsize the workforce, decide which treatments and medicines are to be utilised and how resources should be allocated and used within the clinic. They are also in direct control over the care-unit managers, section managers and unit managers.

The clinic managers that have been interviewed have all pointed out that at their level of management, communication is the most important and effective form of control that they can

exercise. Even though the balanced scorecard is the formal document that is supposed to control the actions of personnel it seems as though it has a weak impact on the medical professionals. One clinic manager explained that although most of the personnel are aware of the balanced scorecard it does not affect their daily work or the decisions they make. Instead, it is up to the clinic managers to communicate what goals are to be achieved, what actions that are preferable and the priorities that they see necessary. Another clinic manager stated that the medical professionals are much less aware of the importance of reducing costs and improving efficiency than managers and emphasise that it is the responsibility of managers to communicate and enhance the awareness of it. All of the clinic managers have, therefore, stressed the importance of meetings as a forum to communicate and manage the clinics.

4.2.3 Professional background

Clinic managers at the Sahlgrenska University Hospital have a background as medical professionals and the majority do not have any education in economics or business administration. Two of the interviewed clinic managers express that they feel that they lack a certain amount of knowledge in these fields, however, all of them have pointed out that a background as a medical professional is vital.

The reason for this is twofold and has to do with acceptance and understanding of the workplace. First of all, they believe that it is easier to gain acceptance as a manager at middle level with a background as a medical professional. Most importantly, it means that the clinic managers will have a better ability to communicate with the medical professionals and a greater understanding of their daily work, norms and capabilities. Furthermore, as the person that are accountable for meeting the budget and improving efficiency in the clinics, it is beneficial for clinic managers to have a background as a medical professional. This will give them a greater knowledge of what treatments and processes that are necessary and what the reasonable cost should be. As a clinic managers points out, not being a medical professional would put a manager in a clear disadvantage when making decisions related to economy and efficiency. They do not know what is necessary and what is not, which gives the medical professionals a clear advantage as they are the experts.

4.2.4 Accountabilities

The clinic managers are held accountable for a wide range of formal responsibilities and performance targets that are given to them by the top-management, namely the hospital director and the divisional managers. The formal document that governs the clinic managers is the balanced scorecard, however, all clinic managers have expressed that the budget is the management tool that impose the most direct form of control. Nonetheless, it is important to point out that the clinic managers are accountable for fulfilling all of the performance targets of the balanced scorecard and for meeting the budget. The clinic managers have little authority to determine what these targets will be but the decision of how they are to be achieved is entirely their responsibility. Clinic managers, thereby, have a certain level of

authority but no influence over the targets they are to achieve and one clinic manager described the management by saying:

> *"I still feel that the organisation is centrally controlled. SU's best branch: responsibility without authority"*

4.2.5 Cooperation between clinics

An aspect of the hospital management at the Sahlgrenska University Hospital that is important to consider is that the organisation is highly decentralised. The clinics within each of the divisions are specialised in different medical fields and there are strong dividing lines between them. In addition, the resources that are in control by each of the clinics vary in terms of both type and volume. To be more specific, clinics have a varied amount of beds, operation wards and medical equipment and are forced to share these in order to carry out the necessary healthcare services that patients demand. What this means for the clinic managers is that they do not own their means of production themselves but have to use the resources of others. Thus, in order for the hospital to offer its patients the healthcare services that they demand, clinics are forced to cooperate and share resources.

In our interviews, it has been apparent that this is an aspect that managers feel makes the process of improving efficiency and meeting the budget in their respective clinics more difficult and that the ability to cooperate is a significant determinant of how successfully they can realize greater efficiency. The clinic managers put a lot of effort and time into planning and managing the cooperation between clinics but describe it as a heavy and complex process. The capacity of each clinic differs and in some cases a specific type of skill or equipment can only be found at one clinic that has to share these with all others. This is something that easily can give rise to resistance and conflict between the clinics, which is why planning and communicating with each other has become an integral part of being a clinic manager. In most divisions, clinic managers meet once a week to plan schedules for the use of time and resources and something that is highlighted is reducing slack in the system, that is to say unoccupied resources and time.

This is also a problem that has been observed higher up in the organisation and there have been directed efforts to improve the basis for cooperation between the clinics. According to the hospital director, the organisation has become less sub-optimised than only five years ago, which has resulted in less conflict. Because of the strong decentralisation there has been a tendency among managers to blame problems on other clinics and this has been an issue when it comes to upholding accountability for each manager. For that reason, methods of joint production planning have been introduced that are based on regular meetings with all the responsible managers in which a fixed production plan is agreed upon.

4.3 Budgeting at the Sahlgrenska University Hospital

As the hospital director explains, the Sahlgrenska University Hospital is funded by the taxpayers and it is the responsibility of the hospital director and managers at different levels to make the most of these funds. Compared to companies in the private sector, however, the manager at Sahlgrenska has virtually no possibilities of increasing their income as this is more or less entirely fixed in the budget. This leads to a budget process that differs from the one in the private sector where managers, at least to some extent, can control and attain new incomes throughout the budget period by managing the supply. This makes the budget process, for a clinic manager, more complex and harder to manage since their performance is not reflected in their income and their only mean for meeting the budget is cutting costs. However, since the overall objective for the hospital is to provide a good and equal health and not to pursue a positive financial result, the main economic goal for the managers is to maintain a balanced budget. The total costs should match the proceeds and thereby the hospital will achieve break-even. The purpose of Sahlgrenska University Hospital is to provide as high-quality healthcare as possible and that must be optimised within the framework of their available resources by being as efficient as possible.

4.3.1 Setting the budget

The board of directors of the Sahlgrenska University Hospital set the budget based on an economic profit and loss budget. The income in this budget is determined after a dialogue with many healthcare committees. There are 12 healthcare committees in the region of Västra Götaland and their assignment is to be representatives of the population and to identify the population´s need for healthcare. They are, in the regional management model, the people sitting on all the money to commission healthcare from hospitals and primary health centers. What this means is that the budgetary conditions are basically fixed. The hospital director describes it as:

> "W*e get a big bag of money that should be managed as efficiently as possible and this bag of money is essentially finite, it is predefined*".

Thus, a clinic manager at the hospital gets its financial conditions in the budget from a superior manager and there are virtually zero degrees of freedom in the clinic manager´s budget since someone else always determines the limitations. This is the case for all managers at the Sahlgrenska University hospital.

4.3.2 The clinic managers role in the budget process

The clinic manager is held accountable for the overall financial result at his or her clinic and as mentioned above, the main goal for them is to achieve a balanced budget. Since the income of the clinics is primarily fixed, it is first and foremost the costs that one can affect as a clinic manager. As a result, the clinic managers´ efforts to meet the budget are to a large extent a cost-focused process. To achieve a well-planned organisation and activities is thus essential for every clinic manager. Thus, their work is a lot about reviewing the operational activities,

norms for staffing and how to control the flows in an efficient way to optimise short lead times. It is a matter of how to increase the quality and how to improve the healthcare process with less resources involved.

4.3.3 Budget control

The budget control is relatively tight at the hospital. The budget of a clinic manager is reviewed every month and if the outcome exceeds the periodised budget, the manager is expected to take action before the problem takes the upper hand. Hence, if a clinic manager reports a budget deficit they are expected to report what actions they are planning to implement in order to overcome the deficit and thereby achieve a balanced economy. The hospital director said:

> *"The only condition really for us to be able to achieve our financial goal is that all managers contribute with their part and so to speak have managed to achieve their budget targets. Logically it is easy, but in reality it never turns out that way. The last two years we have had the situation that those who have reported a budget surplus have exceeded those who have reported a budget deficit, so that the overall economy of the Sahlgrenska University hospital has been able to balance".*

One clinic manager said that one significant reason to why the entire hospital has been able to show positive results the last years is that they now have a better and more committed top management. They demand information and follow it up closely and this makes the clinic manager more committed and it makes them realize that their interim statements are important. This process provides inspiration and motivation in the pursuit to deliver a result that is within the budget. Thus, this review, or control, of the monthly economic development is an important part of creating an incentive for all managers in trying to achieve a balanced economy. The clinic managers now have superior managers who show interest in and hold them accountable for the economic performance.

4.3.4 Clinic managers view on budgeting

The clinic managers that have been interviewed for this thesis are all of the same opinion, that the budget is the most important control system at the Sahlgrenska University Hospital. For example one clinic manager said:

> "*The most important control system and the highest prioritised target is the budget and being able to meet the budgetary targets*".

This manager also said that the budget and the care guarantee (patients must receive treatment within 90 days) are the two most important things to achieve for the clinics right now. They are all of the opinion that the budget process, trying to achieve a balanced economy, takes up a large proportion of their time. However, the opinion whether or not this is a negative thing

differs among the clinic managers. Some managers, of those interviewed, have accepted the tight budget control as the reality of their roles as clinic managers.

One clinic manager is experiencing severe difficulties in achieving a balanced economy and has been forced to focus on cost-reductions. The clinic is a large and complex one and it has reported negative results for several years. According to this manager, one problem in trying to correct this deficit is that almost the only cost that he or she as a manager can affect is the cost of personnel and the clinic has already made major downsizing efforts there. The number of staff has decreased by 100 employees in 2.5 years, wards has been shut down and with an occupancy rate of 106 percent in the wards it is virtually impossible to make further cuts in personnel without reducing the quality and volume of care. The clinic manager has monthly follow-up meetings with his or her superior managers and controllers, where they review the status of the economic budget, how it looks, what is causing the deficit and where they think this will end up. There is also an on-going analysis of the clinic, where two neutral clinic managers are making a review on how the clinic is run. According to this clinic manager, one problem is how they allocate revenues at the divisional level and this resource allocation is basically based on the previous year. It would be good to do a review of the entire division to see if there is a misdistribution of the resources available. It may well be the case that there is some slack among those clinics who are reporting a positive financial result.

4.3.5 Budgeting and efficiency

When asking the hospital director if he thought if the budget process was a good instrument in order to make the clinics, thereby also the entire hospital, more efficient he replied:

> "*Yes, absolutely. Today, we cost less than what we were doing the same time in 2008, in fixed prices. We have no basis for that we are engaged in something other than a better health care and we conduct more health care. Thus, we have become more efficient in terms of both volume and quality. We are conducting more health care, at a higher quality and to a lower cost that is to say that we are more efficient*".

However, all clinical managers interviewed have implied that they think that their clinics now are close to the limit of how much that can be downsized without having a negative effect on the care guarantee and the quality of the services provided. Just recently, we have seen indications of this in the Swedish media. The newspaper Dagens Nyheter and the TV4 News both have published articles saying that private health insurances are increasing drastically in Sweden. The reason for this is that the people think that the waiting lists are too long in the public health care system and the purpose of a private health insurance is to provide a quick access to health care. TV4 made an interview with a manager from a Swedish insurance company, and he thought that it is likely that one million of the population have health care insurances within a year. (Dagens Nyheter, 2010 and Malmodin & Eriksson, 2011)

4.4 The Balanced Scorecard at the Sahlgrenska University Hospital

According to the hospital director, the balanced scorecard is the single most important control system at the Sahlgrenska University Hospital and it is a management control system used in order to achieve balance between all different sorts of conflicting performance targets. The ambition is that all existing performance targets in the balanced scorecard should be equally important. All these targets should be achieved, otherwise one can not achieve balance. The balanced scorecard is a control document used to help balance conflicting performance targets of for example the care guarantee while maintaining a balanced financial result.

The primary goals of the Sahlgrenska University Hospital are divided into five perspectives in the balanced scorecard. Each perspective has one long-term goal, four years, and these long-term goals are set to ensure that the organisation are developed in accordance to the strategy, vision and values. The short-term goals and performance targets are set over a one-year period and this is to ensure that the long-term goals will be achieved. Action plans together with more concrete activities are designed in order to ensure that the short-term targets will be achieved. (Sahlgrenska Universitetssjukhus, 2009)

The balanced scorecard of Sahlgrenska University Hospital consists of five perspectives (Appendix 3):

- The patient and customer perspective
- The employee perspective
- The process perspective
- The economic perspective
- The research and development and educational perspective

The board of directors at the Sahlgrenska University Hospital determines this balanced scorecard based upon targets set by the regional council. The content in every perspective, what is measured and reviewed, is revised every year in order to customise it towards what should be Sahlgrenska´s part in fulfilling the regional goals set by the council. Each perspective is measured and evaluated based on different performance targets, for example in the patient and customer perspective one performance target is if patient feel that they have been treated in a respectful manner and in the employee perspective one performance target is the absence due to illness among the employees.

The number of performance targets may vary a bit on the clinic level as each clinic can adapt and complement the scorecard, making it more tailored to their needs. This can be done as long as it falls is in line with the overall scorecard of the Sahlgrenska University Hospital.
The hospital director said that it is obvious that from the regional council, we can not capture everything that is important for a single clinic in order for them to control their daily operations and this is why there is room for a clinic manager to complement the balanced scorecard, but there is very little room to fiddle with the targets set by the council, these targets apply to every one.

4.4.1 Review

Every divisional manager is reviewed on how the division has performed, based on the targets set in the balanced scorecard. They report monthly to the hospital director according to a determined and agreed template, which is based on the balanced scorecard. The performance of the clinic is thereby reviewed by the clinic manager´s divisional manager, this is inter alia done by the use of interim statements. Each clinic manager is responsible for how well their clinic is achieving the targets set in the balanced scorecard. If a clinic seems to be failing in achieving the targets set in the balanced scorecard, the clinic manager is expected to take actions in order to correct the problem.

4.4.2 Clinic managers view on the Balanced Scorecard

As mentioned above, the balanced scorecard is said to be the most important control system at the hospital. However, this is not reflected in the daily activities if the clinic managers. They all recognise the balanced scorecard as a control instrument but they do not work actively with it throughout the year and they all think that the budget is much more important in their work.

The clinic managers all complement the overall scorecard of the Sahlgrenska University Hospital to their own needs. One problem lies in implementing the balanced scorecard to the employees that are close to the daily activities. Today, if a doctor where to be asked about the balanced scorecard would he or she most likely not know what it was. For a clinic manager, the balanced scorecard works more like a dormant document that they audit once a year in order to specify which goals and target figures that are important and will be followed up.

According to the hospital director this is a problem that they are aware of and he believes that how far the clinic managers has come with the work on the balanced scorecard varies among them. The hospital is currently testing new methods in order to get the clinic managers more involved. All clinic managers and divisional managers are planned to have a meeting together with the top management in order to work through how the process of the balanced scorecard should look. This will hopefully have the affect that the balanced scorecard becomes a more active document.

4.5 Quality indicators at the Sahlgrenska University Hospital

At the Sahlgrenska University Hospital, measures of the quality and the efficiency of performances of various kind are used as a way to make comparisons with other hospitals as well as between subdivisions at different levels within the hospital. The hospital director describes both kinds of comparisons as important because they are drivers of change and puts different units performances in relation to others. By making comparisons it becomes apparent how well the hospital or subdivisions are performing compared to others and serves to motivate managers to achieve performance targets as failure to do so come out in the open.

At national and hospital level, quality indicators are used in part to make comparisons but primarily in order to build registers that can be use in order to identify trends of what kind of treatments works the best in terms of patients gaining better health but also to find out which are the most efficient in terms of less patients having to go back into treatment due to complications and which resources are necessary and not. To be more precise, hospitals in puts different regions of the country often use different treatments for the same kind of disease and through the registers doctors can find out which treatment are the most successful and efficient. Most importantly, it reveals which treatment that has the highest rate of patient being cured but in cases in which a less costly and less resource-consuming treatment proves just as successful as others it also helps hospitals to become more efficient.

At the clinic level of management, quality indicators are much more specific and usually easier to measure, however, making reliable and fair comparisons are perceived as hard by the clinic managers. At an individual clinic it is considered fairly easy to measure the efficiency of the operative activities. An example that was given during our interviews of how efficiency is measured is the number of specific surgical operations that are carried out under a particular period of time and how many of these were without complications as well as the cost of each minute in operation. One of the clinic managers also stressed the importance of measuring the rate in which clinics are overcrowded and are forced to relocate patients and if this is done properly. The reason for this is that these circumstances do not necessarily have to be the cause of too many patients but because of inefficient relocation of patients and cooperation between clinics. A part of this is also measuring lead-time, that is to say the time in which a patient arrives at the hospital and is under treatment.

The measures of quality and efficiency in clinics described above are primarily used within specific clinics and not in order to make comparisons between different clinics. The reason for this is that the measures are perceived as being too specific for each of the clinics, which vary in both size and complexity. For that reason, the measures are considered to be lacking in reliability and validity and inappropriate to use comparatively. However, one of the clinic managers emphasises that comparisons between clinics should be applied to a much larger extent than it presently is. The manager recognizes that the differences between clinics are great when it comes to being overcrowded and having to use extra personnel and overtime in order to maintain necessary activities. The manager put forward that this is a problem that undermines the ability to plan an efficient management and that are not dealt with properly because comparisons are insufficient and the boundary lines between clinics too distinct. The

managers is of the opinion that all clinics should be reviewed concerning their level of efficiency regardless of their financial performance. By doing so, it would be clarified if the reason that some clinics have negative results is explained simply because of inefficiency or if different clinics are given different conditions to start from. On the question on how comparisons are conducted between clinics the manager gave the answer:

> *"Very bad! Worthless! Do not touch me!"*

Moreover, both the head of the development unit and the clinic managers consider the quality indicators to be too many. As they put it, the amount of measures undertaken in healthcare is vast and, even though, there is a lot of effort put into reviewing these there are rarely any consequences related to them.

4.6 The medical profession at the Sahlgrenska University Hospital

According to the clinic managers, there has been a radical change regarding the medical profession's relationship towards efficiency and cost control during the course of their career. As they explain it, the prior generation of clinic managers were active during the "happy days" when there seemed to be no limitations when it came to resources. They never experienced any shortages in funding and were used to getting increased appropriations each year. The culture was heavily influenced by this circumstance and being efficient was far from a priority. Moreover, the clinic managers did not have the same kind of authority as they do today but were seen as representatives of the their respective speciality. Hospital management was in the hands of the medical profession in a much more profound way and the professional values where determinant and managers were seen as unnecessary. All of this started to change during the 80's when the economic conditions changed for the Swedish healthcare system and tight budget constraints were introduced in hospital management. Professionalism was replaced by managerialism and the role of clinic managers became equivalent to a manager in any other organisation (Öfverström, 2008).

The clinic managers that we have interviewed, who are medical professionals, are all in line with the importance of efficiency and cost controls. However, they point out that the professionals without managerial experience, meaning doctors and nurses, are to a lesser degree aware of this importance. Still, they describe that it is relatively high compared to only a few years ago and that there is no real resistance towards pursuing greater efficiency and cost controls. One clinic manager described the situation as following when asked if there is any resistance towards efficiency measures:

> *"I think so. We work on it all the time but there will always be a resistance against changes but if you do not understand it (the need of efficiency) you almost have to quit."*

The reason for this is that the steps that have been made to achieve greater efficiency have not been to the disadvantage of the individual patients. Instead it has lead to a new way of

thinking where old routines are being questioned and doctors have started to think twice about what in a patient´s treatment is necessary and what is not.

4.7 Conflicting interests at the Sahlgrenska University Hospital

When asked about what interest clinic managers perceive as the most important the answer has been that accessibility is the priority followed by meeting the budget. The quality of the healthcare services, or rather the improvement of it, is nonetheless seen as important, however, it comes second to the other two priorities. On grounds of principle, the clinic managers do not perceive that making hospital management more efficient is in direct conflict with maintaining a high level of accessibility and quality of healthcare services. On the contrary, they seem to believe that efficiency comes hand in hand with making hospital management better both for the organisation itself and for the patients. However, the problem is that the Sahlgrenska University Hospital experiences an increased demand for healthcare services but has no possibility of expanding its operations because the funding and supply of resources are close to static. As a clinic manager puts it, the ability to achieve performance targets related to quality at the same time as you have to save money and attain a balanced economy is the difficult part of being a clinic manager. Another clinic manager said that:

> *"Everyone understands that the medical services cannot expand, it is not possible… We need to keep the economy in check. On the other hand there is a limit, I do not think that it is possible to downsize at my clinic"*

Because of the situation described above, clinic managers are forced to improve the efficiency in their clinics to such an extent that it may at times conflict with the accessibility and the quality of the healthcare that they offer. The extent to which clinic managers are exposed to these conflicting interest varies according to size and the level of crowding of patients at the clinics. The clinic manager responsible for the largest of the clinics out of the managers that we have interviewed has been forced to make relatively big downsizes during the last two and a half years. This is despite the fact that the demand of healthcare services at his clinic is at the same level, if not increasing. This impacts on the clinic´s ability to uphold the accessibility and the manager feels it has been downsized as far as it is possible if the clinic is to be able to run its operations. Not being able to downsize any more, the clinic has few actions to choose from when it comes to being able to meet the budget. As it is now, a large part of the clinics costs that could be reduced come from personnel working overtime, however, without it the clinic would need to lower the standards of accessibility and quality of healthcare.

At the same clinic, actions have been taken in order to reduce the costs of medicines which is one of the few costs of the clinic that it can cut down. What has been done is that a list of 30 medicines has been created and in order for a doctor to use any of these they have to ask the council for permission. The doctor has to write a report for each individual patient that has to be well-founded, otherwise they will not be granted permission to use the medicine. In other words, the individual doctor do not have the authority to balance the interests of reducing

costs and upholding the quality of healthcare services but this is something for the council to decide. An interesting example where there was a clear conflict between the cost of healthcare and the quality of it for an individual patient is the case of a 79 years old woman that was treated at a clinic at Sahlgrenska. The patient suffered from heart failure and a rare disease that presumably could be cured with a specific type of medicine. This particular type of medicine would cost the clinic 3 million SEK every year and even though it may stop the disease there was no telling if it would stop the heart failure or not. It was therefore decided that the woman would not be given the treatment on an ethical basis, due to the medicine´s expensive nature other patients would have to be denied treatment if it were to be used. In other words, there was a strong conflicting interest between cutting costs and giving an individual patient treatment in which the economic rationality had the upper hand.

5. Analysis

In this chapter an analysis is conducted out of the findings in the empirical study and the theoretical framework. The analysis starts by addressing the budget process at the Sahlgrenska University Hospital and questions if it leads to efficiency. This is followed by an review of the medical profession and conflicting interests.

The rationalisation and restructuring efforts in hospital management, that began in the 1980s, with the so-called New Public Management have very much affected the Sahlgrenska University Hospital. We have recognised that the hospital uses many methods and models originally derived from the private sector. The organisation is highly decentralised with tight result controls and clear responsibilities for managers at different levels. From what we have understood, there is today a much more distinguished focus on the financial results in the hospital than it was during what a clinic manager called "the Happy days" when the hospital sector flourished with constantly increasing public revenues.

5.1 The Budget process

According to Merchant and Van der Stede (2007), the planning stage is an important part of the budget process. This planning process force managers and employees to think about the future, to discuss ideas with others in the organisation and to be committed to achieve goals that will serve the organisation´s interests. The author defines planning as decision making in advance. Effective planning processes make control systems proactive, not just reactive. Another purpose of the planning process and budgeting is coordination, it should contain a top-down communication of goals and priorities and a bottom-up communication of resource needs, opportunities, constraints and risks. It should also involve a horizontal communication, between units that will enhance the ability to work together towards the common goals. Another purpose is to give the top-management oversight, in the form of preaction reviews, as plans are examined, discussed and approved by higher authorities. The final purpose is to generate motivation for managers, the plans and budget become targets that affect the manager´s motivation because the targets are linked to performance evaluation. In other words, the level of difficulty of the set targets and the review of them will affect the managers' motivation. (Merchant & Van der Stede, 2007)

In regards to this, there is much criticism that can be put to light, from a clinic manager´s perspective, when analysing the budget process of the Sahlgrenska University Hospital. The clinic managers at the hospital are involved in and very much responsible for what Merchant and Van der Stede calls the operational budget, the financial plan for the next fiscal year. It is the aggregated result of all clinics that constitutes the final financial result of the Sahlgrenska University Hospital. Unfortunately, these managers have very little or virtually no influence at all when it comes to setting the budget limitations and performance targets. As mentioned by the hospital director, the budget limitations are always set by a superior manager and this is the case for all managers at all hierarchical levels at the hospital. Hence, in our opinion, the foundation of the budget is very much a top-down communication and this may have a negative affect on the implementation and motivation. The role of the clinic manager is to

plan and make sure that the daily operations are run in such a way that the costs of the clinic will fall within these budget limitations. Hence, the planning process for a clinic manager only concerns how to reduce costs in order to achieve a balanced budget.

Wildavsky (1975) wrote about the budget process as a bargaining game between advocates and guardians (Wildavsky, 1975). Our interpretation of this is that the medical profession in a clinic can be seen as advocates that want to protect the activities of the clinic and thereby wants as much resources as possible. In this context, the role of the clinic manager is to be a guardian who has to ensure that the resource consumption is being kept to a minimum. These roles as guardians and advocates can be different depending on between which stakeholders the communication takes place. For example a clinic manager is most likely an advocate when communicating with top-management and the top management will thus be guardians.
According to us, the structure of the budget process with responsibilities and what one can influence as a manager results in that the clinic manager in his or her daily activities must take the role as a guardian. Since virtually the only thing that clinic managers can influence is the costs, their budgetary process becomes very much cost-focused. The clinic managers, interviewed, perceive that their work has a strong focus on chasing costs, rather than focusing on the more qualitative targets. This will be a strong side effect when having such a tight budgetary control under these circumstances as they do at the Sahlgrenska University Hospital.

We have identified the clinics as profit-centers, which means that the clinic manager is responsible for the financial result of the clinic. One critical question to ask is whether the manager of a profit-center has significant influence over both revenues and costs (Merchant & Van der Stede, 2007). The empirical study has shown that this is certainly not the case for managers at the Sahlgrenska University Hospital, since the revenues are virtually fixed. The result of this is that the relationship between what one can influence as manager does not entirely correlate with the responsibility that one has as a manager. This makes the budget process more complex and may cause unmotivated managers. However, we believe that this is something that is hard to change and that the clinic managers have to accept and learn to live with this, since the healthcare in Sweden receives it´s funding from income taxes.

Another part of the budget process, at the hospital, that can be questioned is how the budget targets are set. According to Merchant and Van der Stede a budget target should be challenging but achievable in order to for example create motivation and a winning atmosphere (Merchant & Van der Stede, 2007). In regards to this, we think that to have a break-even budget target, as they do at the Sahlgrenska University Hospital, can have a negative effect when trying to make the hospital more efficient. This is also questioned in a review of the management control systems of hospitals in the region of Västra Götaland, made by Ernst & Young in 2002. They wrote that an organisation that does not require budget targets set with a reasonable profit will face major risks for budget deficits because of for example uncertainties in projections of demand. They also posed the problem that break-even budget targets do not provide the same incentives for efficiency or other actions for improvement, as a positive budget target. Another problem with these targets is that they do

not provide any incentives to improve efficiency for clinics that do not reveal any obvious financial problems. (Ernst & Young, 2002)

This is a problem that we have encountered in our empirical study as well. The clinic manager that was having severe problems with achieving a balanced budget said:

> *"When planning the budget one has to set a budget target that allows for a balanced economy. The question is whether you can achieve this balance or if it is completely unrealistic."*

The budget loses some of it´s purpose when the manager thinks that the targets are unrealistic, the manager will probably feel unmotivated and loose faith in the entire process. This manager also pointed out that it would be good to do a review of all clinics belonging to the same division, in order to detect if there is slack amongst other clinics that do not reveal the same financial problems. This indicates, according to this manager´s view, that the problems with break-even budget targets, as stated by Ernst and Young, can be confirmed.

5.1.2 Does the budget process lead to efficiency?

The budget process is more complex in a public, non-profit organisation that serves a higher purpose than to just generate as much value as possible to the owners. It is easy to find elements that are problematic, but the empirical study indicates that the budget process is nonetheless an important management control system at the Sahlgrenska University Hospital and it still fills a vital purpose. It creates a focus on cost-reduction and thereby minimises the inputs needed to create the wanted output. The empirical study also indicates that the budget process is structured in such a way that almost the only option for clinic managers to accomplish a more efficient clinic is to cut costs and first and foremost the cost of personnel. As the Hospital director stated:

> *"The hospital is conducting more health care, at a higher quality and to a lower cost, that is to say that we are more efficient."*

As long as the clinics can cut the costs without worsening the quality or the volume of output the budget process for a clinical manager fills a vital purpose, but what happens when this is no longer possible? All clinic managers, interviewed, have implied that they think that the hospital is now close to the limit of how much downsizing that can be made without compromising on the healthcare guarantee or the quality of care. As mentioned in the empirical study (section 4.3.5), we have seen indications of this in the Swedish media, more and more of the population think that the waiting lists in the public health care system are too long and are therefore getting private health insurances in order to get quicker access to health care. These articles relate to all public hospitals in Sweden and not just the Sahlgrenska University Hospital, however we think that it is an interesting trend that needs to be noted and that this is an indication of that the Swedish population is of the opinion that the public hospitals are failing in living up to their expectations.

We believe, based on the empirical study, that the problem with the budget process today, at the hospital, is that it focuses too much on cutting costs and the clinics also to some extent fails in seeing the big picture. They are thinking too much about their own unit and are thereby missing the big picture. A change in the process that will lead to a better cooperation between the clinics, a more developed horizontal communication, could lead to improved efficiency as well.

5.2 The medical profession

In our empirical study it has been apparent that there has been a significant shift towards a greater understanding and insight of the importance of efficiency among the medical professionals and that cutting costs are met with a higher degree of acceptance than before. The clinic managers do not feel that the medical professionals oppose actions aimed and improving the efficiency of clinics and establishing cost controls. However, one clinic manager pointed out that this is only true as long as greater efficiency does not have the outcome of a lower quality and accessibility of healthcare services. In other words, it seems like the medical professionals are in line with making the organisation more efficient as long as it does not happen to the disadvantage of individual patients. In cases when it does, the medical profession is likely to become defensive as their primary loyalty is to their specialisation and the patients and not the organisation itself (Hallin & Siverbo, 2003)**.** One such example has taken place at the Sahlgrenska University Hospital where voices have been raised against cuts concerning personnel and resources. The protests was started by a doctor that is of the opinion that the hospital management has become excessively focused on the budget and that this has happened on the expense of patients (Läkartidningen, 2011).

From what we have understood from all of the three clinic managers, the medical profession do not oppose bids for improved efficiency or cost controls in general. However, they have raised the question of how far it is possible to go in this process without impairing on the quality and accessibility of healthcare. Downsizing of personnel and excessive cost cuts is often perceived as counterproductive by the medical profession as their loyalty to the patients are stronger than to the organisation. We have identified that for them, meeting the budget is less important than maintaining a certain level of accessibility and quality of healthcare services on the clinic that they work at and efficiency measures are, therefore, at times met by resistance.

Another aspect of the presence of the medical profession that have an impact on working on efficiency**,** and that we have recognised in our empirical study as well as in theory, is the consequences it has for clinic managers. A big part of making an organisation more efficient comes from establishing a functioning cooperation between clinics, optimal allocation of resources and good top-down management (Ernst & Young, 2002). This may be hard to achieve in hospitals given that there are a number of inherent competitive conflicts between different specialisations over resources, prestige and influence in the organisation that may cause disruptions within the organisation (Öfverström, 2008). Because of this, we believe that efficiency measures may be difficult to implement since the medical profession is associated

with various obstacles related to a successful hospital management. As explained by a clinic manager, the ability to cooperate with other clinics regarding resources, especially beds and operations wards, is a big determinant in the extent to which a clinic successfully achieves to meet the budget and improve the level of efficiency. It is a complex process that consumes a lot of time for clinic managers but necessary if they are to make the most out of the hospitals resources and the inherent conflicts between specialisations may cause disruptions that restrain the ability to improve efficiency.

Moreover, being a clinic manager is not necessarily something that is connected status or authority. Status is something that is achieved in the role of a medical professional and not an administrative manager (Öfverström, 2008). What we have seen in our interviews with clinic managers is that a background as a medical professional is essential to succeed as a clinic manager. Most notably, it is an almost necessary part in gaining the acceptance of clinic managers and also in understanding the workplace. We believe that this is especially important because the clinic managers are the mediator between the administrators at the top-management and the medical profession. What this means is that the clinic managers need to find ways to implement decisions made by administrators that the medical professionals may not agree with in such a manner that the changes are accepted and thus also successfully implemented. We have the impression that, even tough the clinic managers did not feel that this aspect was too much of a burden, the level of successfulness in which administrative decisions are implemented depends on the clinic managers to communicate the importance of it to the medical profession.

5.3 Conflicting interests

At present, the underlying circumstances that give rise to strong conflicting interests comes from the fact that demand for healthcare services are rising while funds and resources remains at a static level. The expected standard of healthcare is as high as ever and the only way of upholding it is a strong focus on greater efficiency. However, the extent to which a hospital can be made more efficient may depend on whether the medical profession perceive it as a risk to the accessibility and quality of the healthcare services. We have the impression that most professionals relate the term efficiency with cost cuts, which are perceived as counterproductive and for this reason the process of improving efficiency may be held back.

From interviews with the clinic managers it has become evident to us that the budget is the central control system in the organisation and that meeting the budget is a top priority. Every clinic manager is expected to achieve a budget performance of break-even and all of them have stressed the importance of efficiency in reaching this target. What we have observed is that because of the strong focus on meeting the budget, efficiency has to a large extent become a cost-focused process. Clinic managers need to cut costs in order to meet the budget and they perceive cost-efficiency as the key tool to do so successfully. The only costs that managers can influence to a significant degree are that of personnel and medicine. The result of this is that improving efficiency in many of the clinics has taken the form of downsizing and establishing strict control over what medicines are to be used. In the eyes of the medical

profession, the focus on cost-efficiency, especially considering the downsizing, impairs on the quality of healthcare for patients and the accessibility to it (Hallin & Siverbo, 2003), and we believe that such a focus will lead to a strengthening of conflicting interests.

As we have learned in our empirical study, the Balanced Scorecard at the Sahlgrenska University Hospital serves to balance five different perspectives and in turn conflicting interests. According to the hospital director, each of the five perspectives are meant to be equally important, however, from what we have understood from the clinic managers this is not really the case at their level of management. They feel that the economic perspective, that is meeting the budget, is the priority and subsequently that all the different perspectives are not equally important. In other words, the balanced scorecard does not seem to balance the conflicting interests successfully, instead, clinic managers feel that the budget comes first and that it is hard to balance with other interests. As such, it appears like the balanced scorecard fails to implement some aspects of the hospitals strategy and balance all of the perspectives.

We believe that the unsuccessfully implemented balanced scorecard is one of the reasons why the clinic managers find the economic perspectives as the one that is enforced and prioritised. Furthermore, one can question if that perspective is appropriate in terms of fulfilling the mission of a hospital as the effects of it has no direct impact on the health of patients. It could be argued, as Niven does in an article on the balanced scorecard in public organisations, that the economic perspective should be secondary to the patient and customer perspective, and fill the part of a supporting function. More specifically, clinic managers should be held accountable for an efficient use of resources but that is not the primary objective of a hospital. Instead what should be elevated in the balanced scorecard is the question if patients are better of from the efforts of the hospital, which places the patient and customer perspective as the most important perspective. The economic perspective should be seen as supportive to the patient and customer perspective and, thereby, it would become clearer for clinic managers how to make decisions related to conflicting interests that arise when the economic perspective collide with the patient and customer perspective. Most notably, this concerns cutting costs in order to meet the budget while maintaining the same level of quality and accessibility at the hospital. (Niven, 2003)

As the Sahlgrenska University Hospital needs to make the most out of the limited resources that it is granted, the importance of cost-efficiency is obvious. Without it, the hospital would risk budget deficits**.** Nevertheless, we find it of interest to question if its beneficial in regards of improving health outcomes. One of the three parts in the overall mission of the hospital is to provide highly specialised healthcare to the people in the Region of Västra Götaland (Sahlgrenska Universitetssjukhus, 2011). Thus, when speaking of efficiency it should be appropriate to look at the relationship between different inputs and health outcomes. While cost-efficiency may contribute to higher value for money in health it does not necessarily lead to better health outcomes and therein lays the conflicting interests (the European Commission and the Economic Policy Committee, 2010). As one of the clinic managers put forward during our interviews, there is a limit to how much a clinic can downsize and cut costs and still maintain the same standard of accessibility and quality of healthcare that patients expect. In

such cases, the manager has to evaluate which of the conflicting interests that is to be prioritises, meeting the budget or maintaining the standard of healthcare at his clinic.

On the other hand, we believe there are other ways to achieve better value for money that do not impair on the accessibility and quality of healthcare and that may even improve it. The perception of clinic managers have been that personnel costs is in large the only cost that they can reduce. However, this is not entirely true as the level of efficiency as a number of other factors have a great impact on the costs of the organisation. First, the top-management of the hospital has to provide clinic managers with clear goals and performance targets for the organisation to be run efficiently. Second, the cooperation between clinics has to be carried out efficiently. This involves exploitation of synergies, flexibility of implementation and functioning healthcare chains. Third, an efficient use of resources and optimal allocation of resources between clinics is vital in regards of reducing costs. (Ernst & Young, 2002)

6. Conclusions

Chapter six presents the conclusions that has been drawn out of the findings of our thesis and provides the answers to the problem definitions.

One of the most stressing issues for the Swedish health care system is that the demand for healthcare services is increasing while the financial funding that is based on tax-income remains at a static level. The need to make the most out of existing resources has therefore been recognised as necessary and a significant focus is directed towards efficiency in today's hospital management. We have identified that this focus is most certainly evident at the Sahlgrenska University Hospital, however, the presence of the medical profession and conflicting interests of the organisation makes it a complex one to manage and restrains efficiency improvements. According to Hallin and Siverbo (2003), the main problem for hospitals is that the available resources are insufficient in relation to the demand for health care. A balance between demand and resources cannot be created by a well-managed organisation, however, it may lead to that the available resources are used more efficiently (Hallin & Siverbo, 2003).

Today, as our empirical study has shown, the problem with lack of economic awareness and acceptance of efficiency actions among the medical profession is in general no longer seen as a barrier or a major problem. The old picture of the medical profession as protective and resource-greedy persons that we have encountered in the theoretical study has now changed. We have recognised that the medical profession at the hospital is no longer perceived as being in direct conflict with the process of making the hospital more efficient and has nowadays a higher degree of acceptance towards costs reductions and efficiency actions. From what we have understood from the interviews, this is much because of the New Public Management reforms and also to a large extent on a generational change within the profession. However, we believe that the relatively high level of acceptance does not infer that there is no resistance to expect from the profession. As our theoretical study has implied, the medical profession is more loyal to the patients than the organisation and its management and are by no means indifferent to conflicting interests.

At the Sahlgrenska University Hospital there is a strong focus on creating a more efficient organisation. Our empirical study indicates that for a clinic manager, efficiency has virtually been interpreted as the same thing as making cost-reductions. One reason for this that we have identified is that clinic managers sees the budget as the single most important control system because of the tight budget control and the structure of the entire budget process. The most direct way to achieve higher efficiency, for a clinic manager, is to cut costs while still trying to maintain the same quality and volume of the health care offered. According to what we have identified in the empirical study, this development is not sustainable in the long run, at some point the limit of how much that can be downsized without affecting the higher purpose of the health care will be reached. In consequence of this focus, conflicting interests have become more apparent. These arise from the struggle to maintain a high quality and

accessible health care with limited resources and an increased demand.

Conflicting interests is a constant factor in hospital management and recently protests has been raised from medical professionals at the Sahlgrenska University Hospital against the strong focus on cost-reductions that they perceive as harmful to the individual patients (Läkartidningen, 2011). We interpret the conflicting interests and the medical profession as an antipole against the pressures of reducing costs and this creates a balance of power in the work of improving efficiency. As a clinic manager has explained, if the downsizing creates a more efficient organisation and does not have any negative effects on the health outcome it is accepted as a much needed improvement. However, as exemplified, changes that happen at the expense of the care of patients are likely to be met with resistance.

In order to gain the approval of the medical profession and minimise the strength of the conflicting interests the hospital needs to emphasise that efficiency has to be achieved through other ways than simply cutting costs. All of the clinic managers interviewed were of the opinion that they are close to the limit of how far they can cut costs and it seems as though the hospital needs to focus on other methods of improving efficiency. A problem that we have identified is that the balanced scorecard does not successfully manage to balance the conflicting interests and it needs to be implemented better at clinical level. The budget still fills a vital purpose by imposing cost control but it is of essence that it is incorporated in a control system that successfully can manage to balance the existing conflicting interests. We think that this could be accomplished if the balanced scorecard was remade so that it would become a more active and successfully implemented control system throughout the organisation.

Finally, what we have found is that the medical profession do not principally oppose bids of higher efficiency, however, the present focus on cost reductions may aggravate the conflicting interests to such an extent that the Sahlgrenska University Hospital comes to a point where the acceptance of it reaches its limit. We believe that the hospital should put more effort into improving efficiency in the fields that the clinic managers have stressed the importance of in our interviews. That is, optimal resource allocation, functioning cooperation between clinics, better comparisons among clinics and greater authority for clinic managers in the process of setting budget- and performance targets.

In conclusion, our study indicates that the medical profession does not oppose the process of making the hospital more efficient as long it is beneficial to the individual patients. The present focus of cutting costs in order to become more efficient exposes the hospital for the risk of not being able to maintain the same level of quality, which in turn strengthens the conflicting interests.

7. Suggestions for further research

In this final chapter suggestions for further research is made.

The case study that we have conducted has spanned during a short period of time and as a result only includes a small number of respondents. For this reason, the thesis is limited in the sense that the conclusions cannot be seen as scientifically valid.

We therefore believe that it would be interesting to do a more thorough study of how conflicting interests and the medical profession affect the process of making the Sahlgrenska University hospital more efficient. A case study that includes a greater number of respondents and covers managers and professionals at different levels in the hospital would hold a higher scientific validity and give a wider perspective that could provide more meaningful conclusions.

Furthermore, what we have found in our case study is that the Sahlgrenska University Hospitals do not successfully manage to balance the existing conflicting interests. We have identified a need to develop the Balanced Scorecard so that it is successfully implemented and achieves to balance all perspectives. It would be of interest to conduct a case study that addresses this issue.

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8.5 Verbal sources

8.5.1 The Sahlgrenska University Hospital

Personal interview with *Clinic Manager 1*. (2011-18-04). 90 minutes.

Personal interview with *Clinic Manager 2*. (2011-29-04). 60 minutes.

Personal interview with *Clinic Manager 3*. (2011-11-05). 60 minutes

Personal interview with *Hospital Director*. (2011-09-05). 60 minutes

8.5.2 Region Västra Götaland

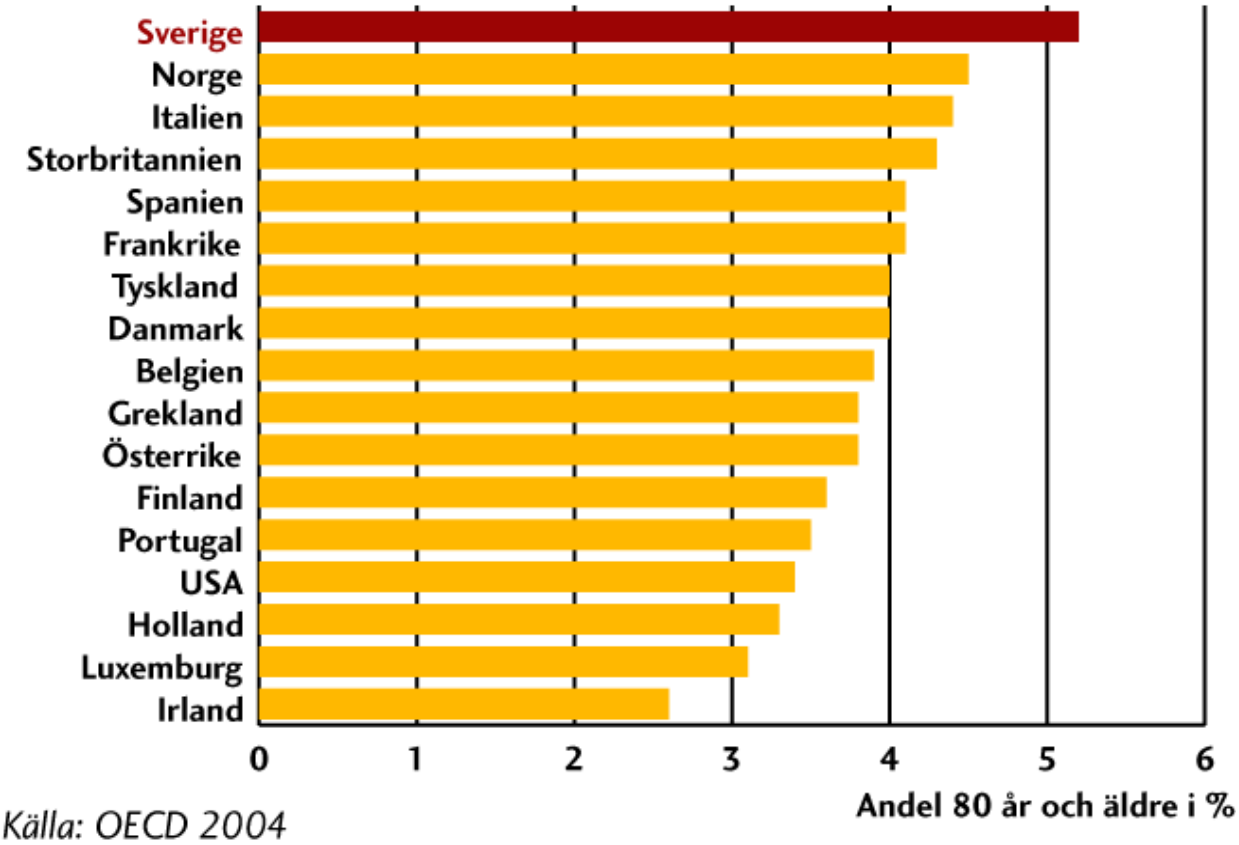
Personal interview with *Head of development*. (2011-21-04). 60 minutes

9. Appendix

9.1 Appendix 1.

(Sveriges Kommuner och Landsting, 2005)

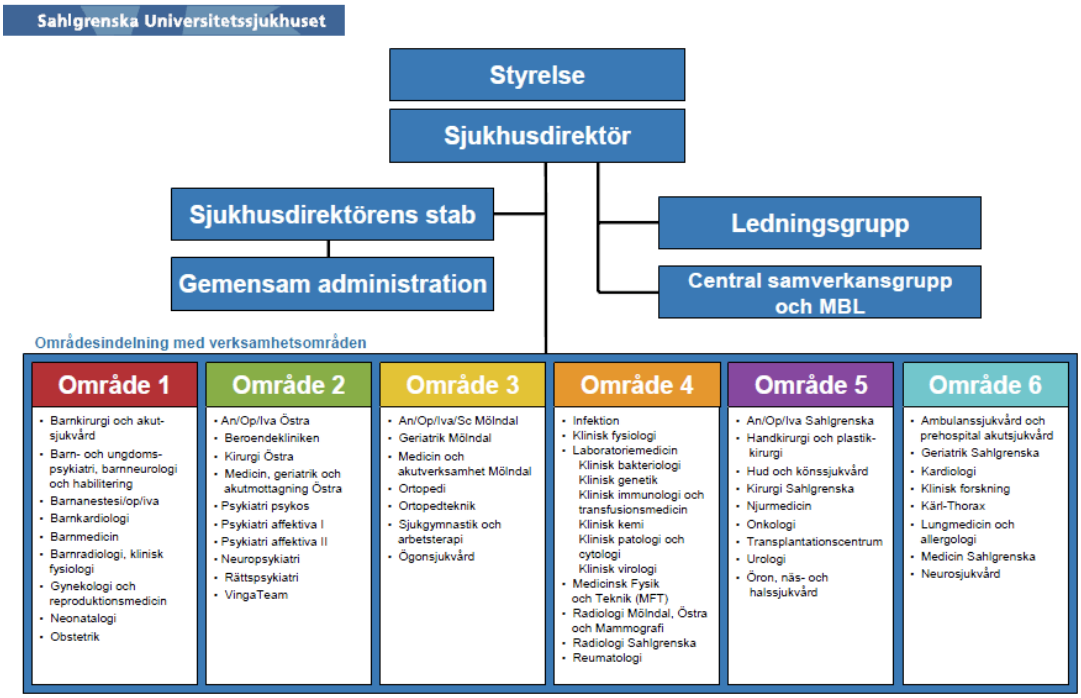
Befolkning 80 år och äldre i procent av totalbefolkningen 2002.

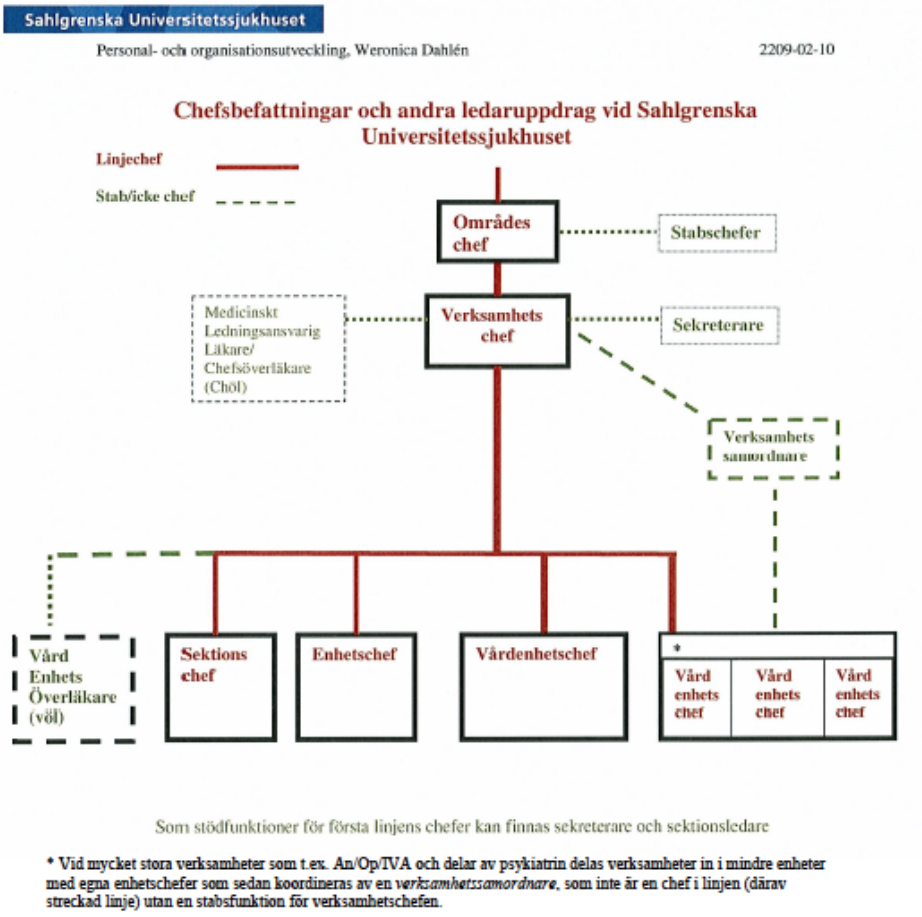


Källa: OECD 2004

9.2 Appendix 2

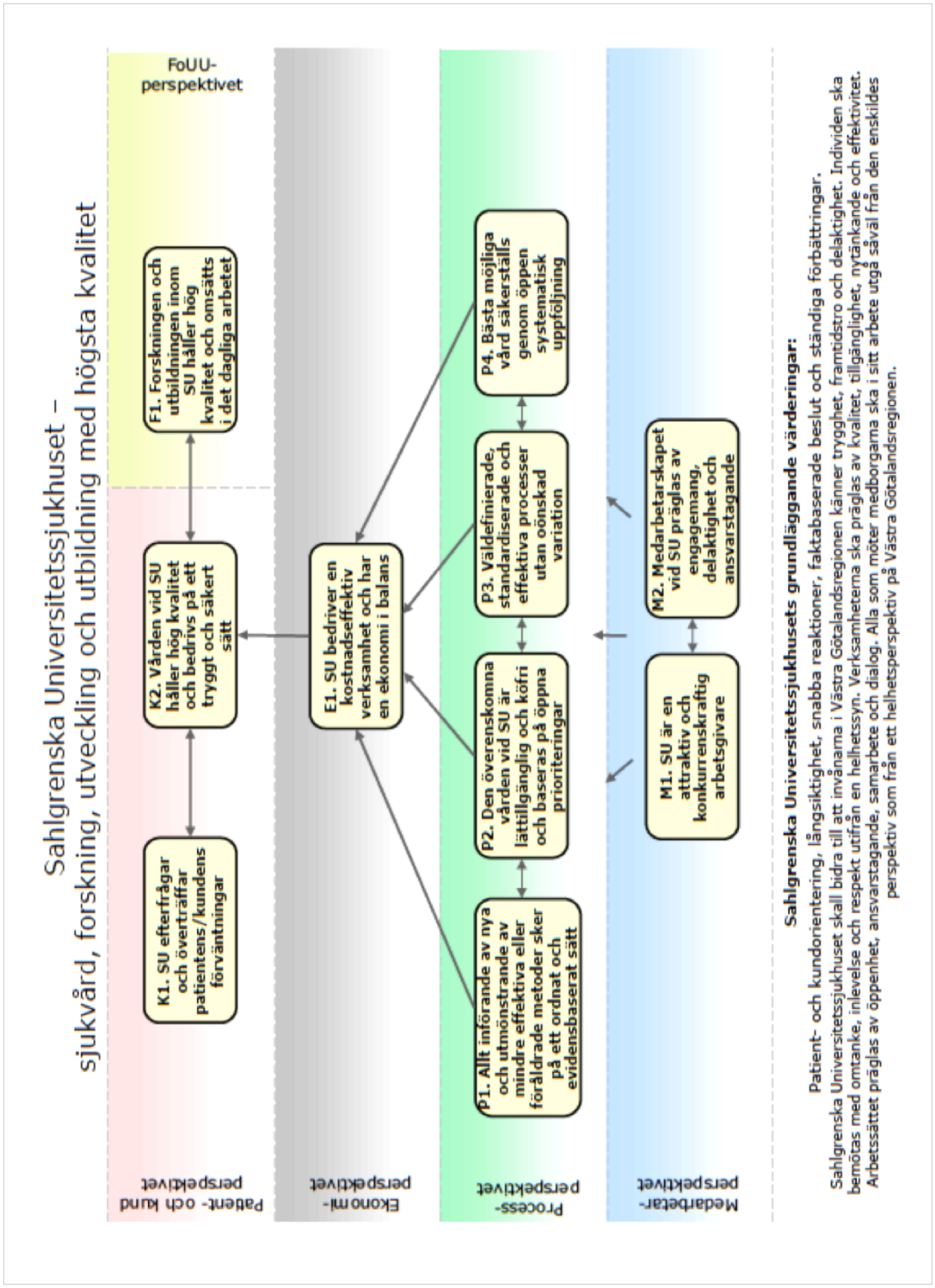
(Sahlgrenska universitetssjukhus, 2011)





9.3 Appendix 3

(Sahlgrenska Universitetssjukhus, 2009)



9.4 Appendix 4

9.4.1 Guide for interviews

1. Arbete, bakgrund

2. Hur ser Sahlgrenska Universitetssjukhusets organisation ut? Vilken roll har verksamhetschefer i denna?

3. Definiera vad effektivisering innebär inom sjukvården?

4. Har du märkt av ett ökat fokus på effektivitet under de senaste åren?

5. Hur gestaltar sig effektiviseringsarbetet i sjukvården? Exempel?

6. På vilket sätt ingår ekonomi och effektivitetskrav i en verksamhetschefs arbete?

   - Ansvar, befogenheter

7. Vilka styrmedel används på sjukhuset och hur påverkar det ditt arbete med effektivisering?

8. Upplever du att det finns en konflikt mellan ekonomiska mål och vårdmål? Exempel?

9. Hur bemöts krav på effektivitet av den medicinska professionen?

10. Hur påverkar den medicinska professionen styrningen av sjukhuset?