UNIVERSITY OF GOTHENBURG

The Journey Towards the Goal is Irrelevant as long as the Goal is Fulfilled

Two coexisting and competing logics in healthcare work

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Abstract

The background to the study presented in this thesis is an organisation that is established within the private healthcare sector and acquired one part of another healthcare organisation and reduplicated the volume of care units. The healthcare industry is characterised by professional work and education is needed to work as a nurse or general practitioner. Healthcare is generally structured that those who are a manager has both medical and management responsibility. This implies that working as a manager in healthcare is confronting different demands, which this thesis is studying. The aim of this study is to explore how managers in healthcare are responding to different demands. This thesis is based on a qualitative case study where semi-structured interviews were the main source of data collection.

To analyse the empirical result institutional logics is used. The conclusions that can be drawn based on evidence found in the research performed in this thesis are that two logics coexist and challenge each other simultaneously, management and professionalism. In this case some situations require different needs and one logic might need to suffer in order to accomplish and fulfil demands of another logic. The logic of professionalism have been stabile over time, nothing has affected how the interviewees are identified towards this logic, as the assignment and patients is the same. The logic of management is however in constant change depending on situation and requirements. One of the most important findings is that in order for an individual to be identified towards multiple institutional logics, collaboration is an important aspect that must be regarded.

Key Words:
Institutional logics, Institutional pluralism, Healthcare, Identification and Individuals.

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1. Introduction

> In a world characterised by increasing institutional pluralism many organizational contexts are becoming embedded in competing institutional logics that impose conflicting demands on organizational members.
>
> Pache & Santos, 2013:4

The background to the study presented in this thesis is an organisation, Alpha, that is established within the private healthcare sector and acquired one part of another healthcare organisation in December 2012. This resulted in a reduplication of care units and employees. Alpha has formulated a business model that the organisation is using to control their decentralised organisation. Focus in this thesis is care unit managers who possess great influence on their own care unit. Their work contains different demands such as providing high quality care and managerial responsibilities such as for example budget and personnel. The reason for performing this thesis within the healthcare industry is due to care unit managers has an interesting position as further will be emphasised.

The healthcare industry is generally structured that those who are manager has a medical education, as nurses, general practitioners or other occupations within healthcare (Axelsson, 2000; Nilsson & Furåker, 2012). In this scenario managers are responsible for medical requirements such providing high quality care for patients, generate a sound recovery as well as being in charge of budget and personnel (Nilsson & Furåker, 2012; Reay & Hinings, 2009; Skytt, Ljunggren, Sjödén, & Carlsson, 2007). This implies that working as a manager within healthcare is confronting different demands (Reay & Hinings, 2009; Scott, Ruef, Mendel, & Caronna, 2000), which this thesis is studying.

Focus on structure healthcare in a decentralised manner was introduced from 1985 in Sweden. The reason to decentralise healthcare was in order to flattening the organisational structure and several middle managers was removed, budget and medical responsibilities was transferred to the head physician. During the period from 1992 the healthcare system was facing a market orientation and privatisation of the public sector occurred especially in the primary care. Quality management was introduced from 1996, and focus was on patient needs and opinions. This have resulted in a new form of centralisation, many clinical departments have been merged into larger units in order to organise the entire episode of care (Axelsson, 2000).

Limited research is conducted on how the individual acts upon these diverse demands (Pache & Santos, 2013), if it is possible to combine the demands to coexist or if they are contradicting each other. Within research there is a gap in terms of when different demands exist and when one demand is regarded as dominant and stabile while others is in constant change. Thus how the individual are responding to this different demands, hence prompting the need for further research being performed within this area, a need this thesis fulfils.

This study aims to explore how managers in healthcare are responding to different demands. Following research questions has been formulated to answer this research aim: *How do care unit managers act upon different demands?* And *how are care unit managers identified with different demands?*

To be able to answer this research aim, a theoretical approach named institutional logics is used. During recent years there has been a growing interest about the concept of institutional logics among scholars (e.g. Friedland & Alford, 1991; Hinings, 2012; McPherson & Sauder, 2013). Institutional logic defines content and meaning of institutions and refer to a common believe system (Reay & Hinings, 2009). Institutions consists of individuals whom are facing logics which can be utilised as a map that consists of knowledge and information which are shared in that context (Scott, et al, 2000). The phenomena of dual or multiple logics has been emphasised, where individuals within an organisation are confronting competing logics (Dunn & Jones, 2010; Pache & Santos, 2013). Hybrid organisations is an organisation where indiviuals are working and institutional pluralism occur (Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011). Dual logics exist for example within the healthcare industry (Greenwood, et al, 2011; Pache & Santos, 2010; Reay & Hinings, 2009) and occupations that characterises by delivering professionalism such as general practitioners, which this thesis is focusing upon. Working within an occupation that characterises of professionalism implies that a certain behaviour, routines and practices has been produced and those individuals have common ways of thinking and dealing with problems (Evetts, 2013). The individual is often loyal towards their profession, colleagues and science rather than the employer. The work requires high level of independence and is sceptical for politicians and manager's supervision and control (Borgert, 1992). This thesis focuses upon two coexisting and competing logics, professionalism and management.

This thesis is organised as follows: first the point of departure is presented, institutional logics, and the concept of competing logics to end with the necessity of identity and logics. Followed by the process of collecting and analysing data. In the next section the empirical result is presented to continue with elaborating and interchangeably analyse empirical result with institutional logics. The thesis ends with a conclusion, practical implications and suggestions for further research.

2. The concept of institutional logics

The concept of institutional logics was first introduced by Friedland and Alford (1991), as a contribution in a book on structural and cognitive isomorphism of organisational fields. Organisational fields refer to an organisation, which are part of institutional life, where individuals and organisations generate comparable services or products. Organisational fields only occur when they are institutionally defined (Dimaggio & Powell, 1983). Further, Powell and DiMaggio (1991) argues that neoinstitutional theory is rooted upon its focus on culture and emphasises on how social structure and action are shaped by institutions and have important consequences. Neoinstitutional theory is one of the most central perspectives in organisational analysis, as stated by Lounsbury (2008). Friedland and Alford criticised the well-established neoinstitutional theory for not considering the actor in a societal setting and

proposed that to understand individual or organisational behaviour these elements must be situated in a societal context (Friedland & Alford, 1991).

Belief system, values and its associated practices, compose the content and meaning of institutions and together defines institutional logics (Dunn & Jones, 2010; Reay & Hinings, 2009). Consequently, the concept offers a relation between institutions and actions, and thus is a crucial phenomenon to understand within organisational fields (Reay & Hinings, 2009; Thornton, Ocasio, & Lounsbury, 2012). Institutional logics, institutional change and organisational fields are connected in several ways, where institutional logics is concerned with organising the behaviouristic aspects within the field (Reay & Hinings, 2009).

Usually institutional logics are perceived as macro-level belief system that form cognitions and has an impact on decision making in different organisational fields (Lok, 2010; Reay & Hinings, 2009). Organisations within a specific field take these logics for granted and uses them unconsciously as rules that clarifies goals, expectations and legitimate activities and is often expressed in the organisational structure and practices. Institutional logics can also be seen on micro-level and focuses there instead on how logics are enacted in everyday life in organisations. Actors can use logics as a tool to influence decisions, justify activities or change. The equivalent logics can be utilised in different contexts to fulfil opposite goals and the actor may choose to use different logics depending on the goal with the situation. This implies that logics are individual established perceptions, how they are constructed, submitted and utilised depends on the actors interest, believes and preferences (McPherson & Sauder, 2013).

2.1 Competing Logics

Institutions are facing increasing demands, which also can be named as institutional pluralism. Several institutional settings are facing competing institutional logics that create conflicts for its members (Dunn & Jones, 2010; Greenwood, et al, 2011; Pache & Santos, 2013). This implies that the member's attitude about logics is grounded on education and professional experience; therefore, the individual's perception is introduced as a consistent set of institutional remarks (Pache & Santos, 2013). In a real-life context individuals are rather exposed to several competing logics simultaneously (e.g. Goodrick & Reay, 2011; Greenwood, et al, 2011; Pache & Santos, 2013), a healthcare profession may obtain training in management (Reay & Hinings, 2009), however, managers in healthcare has often not accomplish formal education in business administration (Scott, et al, 2000). Outside of the educational or professional logics the individual are exposed to multiple logics at the same time, and perhaps some logics are inherited from for example family, partner, religion or market (Dunn & Jones, 2010; Pache & Santos, 2013). While some logics are given through practice of leisure activities such as political or board of directors activities (Pache & Santos, 2010; Pache & Santos, 2013).

Research has been conducted from Reay and Hinings (2009) and their result emphasise that coexisting and competing logics do not always need to be dissolved. Their study stresses how physicians and managers were lead by multiple logics for a long period of time. This implies that multiple logics may be connected with different actors and organistions (Goodrick &

Reay, 2011). Research has also been conducted from McPherson and Sauder (2013) who stresses that actors either resist the new logic or generate dual logics depending on the context. Even though several logics are competing at the same time, guidance on behaviour needs to influence the identification process with specific logics and its related practices. A study conducted by Swan, Bresnen, Robertson, Newell, and Dopson (2010) stresses the need to understand how new institutional logics can generete contradictions and concurrently produce reinforcements of the old logics. Lindberg (2014) has performed a study and the result reveals that multiple logics can be combined, how they are utilised depends on the context within the field and creates a new collection with procedures and objects.

Individuals constitute an important role in determining organisational outcome. Different organisational contexts are surrounded by conflicting demands, which influence how the individual responds, again stressing the need to understand the individuals perspective in competing institutional logics (Pache & Santos, 2013). A powerful mean to create and legitimise norms is education of the individual, as this influence the individual's behaviour and establishes a ground of templates for the future (Goodrick & Reay, 2011). These templates set the stage for work experience as logics constantly is giving feedback of aligned behaviour but also sanctions for contradicting behaviour. Organisations are also producing logics that is embedded and shared in the specific context regarding goals, values and practices, hence creating the logic of professionalism. Following this argumentation individuals are continuously exposed to several and or competing logics, consequently how individuals are influenced can differ between the different logics (Pache & Santos, 2013).

2.2 Logics and identity

Identity is another important aspect to consider when discussing institutional logics in order to understand transfer between logics. Identification can be seen as a way to strive for change where aspects of how individuals impregnate new beliefs, norms and values to institutionalise the new logics (Lok, 2010). Interests, values and identities of an individual are embedded in logics and constitute the base for decision-making and organisational outcome (Goodrick & Reay, 2011).

The identification aspect deals with both social identities such as class, gender or sexuality and self-identity, which creates the individual's own perception of who and what they are. Self-identity is created when participating in multiple logics and continuously shifts and evolves over time and offers several possibilities for identification. This implies that self-identity is neither direct given nor fixed (Lok, 2010). Three levels of identification exists in which individual's can generate the dual paradox of logics in their daily life (Lok, 2010). The first level proposes that self-identity can be used to rework a new logic founded on identity that permits practices to be interpreted in line with prior self-identification and practices. Secondly, identification must not be consistent and unified in which the new logic is used, identification is rather hybrid that can result in contradicting practices with some that referred to prior self-identity and some generates a new logic identification. Lastly, autonomy is important to preserve, in order to distance self-identity from the new logic to not impact on identification in how the new logic is translated rather adopt practices that are more favourable (Lok, 2010). Individuals are facing several different, competing and contradictory

(McPherson & Sauder, 2013) demands in the social world, thus institutional logics is used to manage the complexity.

Research conducted from Pache and Santos (2013) has emphasised the importance of understand the individual relationship to institutional logics. How individuals relate to the different logics depends on the degree of *availability*, *accessibility* and *activation* (see table 1). *Availability* refers to knowledge and information that individuals already possess about a given logic. *Accessibility* refers to the level, which knowledge and information about a fixed logic came to mind and *activation* refers to whether available and accessible knowledge and information really are used in social interaction. Individuals may relate in different levels of a fixed logic depending on the degree of availability, accessibility and activation, they may be *novice, familiar* or *identified* (Pache & Santos, 2013).

Novice implies that the individual has no or limited knowledge or information available about the given logic. Being novice can occur in situations when an individual has not been exposed for the logic, its requests or has not been socialised with other individuals that has been exposed. The novice denotes that individuals are not loyal the given logic and has no intentions to change behaviour for the requested (Pache & Santos, 2013).

Individuals that are *familiar* with a given logic controls available knowledge, which is given through direct or settled social interactions. Even though knowledge is available it is not accessible, nothing that comes first to mind, as no strong links are build to this given logic. The logic is rather familiar, goals and means are proposed, however, no ideological or emotional commitment, it is instead seen as a way to gain legitimacy in order to fulfil requested demands. Nothing that is neither taken for granted nor part of the identity and the degree of loyalty towards the given logic is therefore intermediate (Pache & Santos, 2013). Familiar with a given logic is Lok (2010) also emphasise is of importance, to preserve autonomy and distance self-identity in order to adopt practices that are favourable. Research conducted from McPherson and Sauder (2013) also stress that individuals put effort en agency work when using logics, depending on the situtation and its requirements. Their study of a drog court shed light on that logics who are available are used to manage daily work, often engaging the competing logic. Logics are used to fulfil individual or organisational goals and regardless of the logic used as long as desired outcome is accomplished.

Identified by a given logic as an individual involves that the logic is both available and accessible. The individual is aware of the logic and is both ideological and emotional committed, strongly identified in what to do and whom the person is as well how to relate to its surrounding. Through experience, training and socialisation the relationship is established to the given logic. Different degree of links between individuals and logics should not be viewed separately; it is rather as steps on a continuum. On the one hand, being novice and exposed and socialised to a given logic, leads to a process of familiarisation and on the other hand an individual that are familiar with a given logic, might over time advance in strong and positive links with the logic and in the end being identified with that specific logic (Pache & Santos, 2013). One of the most powerful approaches to influence an individual's behaviour is

through effecting their identification towards the logic and its associated practices (Lok, 2010).

	Novice	Familiar	Identified
Availability (knowledge and information that people have)	0	+	+
Accessibility (degree to which knowledge comes to mind)	0	I	+
Activation (degree to which knowledge is used in social interaction)	0	I	+
	↓	↓	↓
	Level of adherence: Null	Level of adherence: Intermediate	Level of adherence: High

Table 1: Individual's Relationship to Institutional Logics
Source: Pache & Santos (2013:11).

Individuals are facing competing logics at the same time and their reactions might vary depending if they choose a response that is richer than the rejection/compliance contradiction usually assumed. The individual responses are often grounded on social acceptance, status and identity. On micro-level the individuals are applying: *ignorance, compliance, defiance, combination* or *compartmentalisation* (Pache & Santos, 2013). *Ignorance* means an individuals lack of response in relation to institutional demands, it refers to a non-existing awareness of the logics influence. Values, norms and practices that are predefined by a given logic for individuals refer to *compliance*. Competing logics challenges the taken-for-granted compliance, which forces individuals to practice agency when complying with an agreed logic rather than with another one. *Defiance* refers to an individual's obvious and immediate rejection of values, norms and practices arranged by a given logic. Defiance varies from ignorance because it entails awareness and disagreement with resisted logics, responses may vary in their level of resistance, refusal to conform and with efforts to attack contradicting logics in order for them to disappear. Individual may show compliance with given logics and refuse competing logics in a given context, and choose to show loyalty for the competing logics in a different context, this refers to *compartmentalisation* (Pache & Santos, 2013). Depending on time, space and context, the individual display loyalty to one logic and refuses that logic in another context, an example of situation this can occur is in different organisational contexts. Goodrick and Reay (2011) has performed a study on changes in the professional work of pharmacists, their result stresses the need to understand the concept of segmenting, how multiple logics coexist and their impact on different individuals and organisations. In professional work logics reflects some assignments while other work within professional work refer to another logics. Educational standards is regulated by the professional logic, while workplace standards are decided by the organisation. Consequently they argue that competetive logics can coexist through segmentation. It is not neccessary to decide between multiple demands, rather increase demands that must be regarded, in order to

meet regulations from both professional and or organisational requirements (Goodrick & Reay, 2011). *Combination* indicates on an individual's effort to mix some values, norms and practices given by the competing logics. Combining logics is not the easiest assignment due to occurring incompatibilities. It stresses to use either a strategy that involves to use selective connections from each logics or develop new values, norms and practices that produce the competing logics. Responses on logics are different depending whether the individual are facing a single or multiple logics. Assemble complex reactions when facing multiple logics such as compartmentalisation or combination and react less complex such as ignorance, compliance and defiance (Pache & Santos, 2013). Different contexts require different responses from the individual, facing multiple logics demands complex responses, while single logics can be regarded as less complex.

3. Methodology

Case studies are appropriate when answering research questions of *how* and *why,* which this thesis is based on (Yin, 2009). Using case studies implies going in-depth with a specific case and provide a rich description of that specific phenomenon. Moreover, case studies are a flexible method (Hakim, 2000) as it is possible to collect data through several techniques for example secondary data, interviews and observations (Eisenhardt, 1989; Yin, 2009). The main collection of data in this study is based on interviews and secondary data. This implies that the research design is of qualitative character as it deals with individual's own feelings, perceptions and behaviour (Hakim, 2000). Eisenhardt (1989) argues that using case study, as a research design can interchangeably be synonym with qualitative research.

Throughout this study the name Alpha and Delta are fictive names and Alpha are the acquiring company while Delta was the acquired company. Using fictive names is the organisations desire, and fulfils important aspect from Vetenskapsrådet (2002) regarding ethical considerations. The first step was to analyse secondary data, receiving documents, annual reviews, employee survey and an informal interview with the gatekeeper in order to understand the studied phenomena. Important to consider when using secondary data is that the information is produced by the organisation itself and it is significant to eliminate that the data is biased. Thereafter, following the secondary data a process of formulating questions for the interview guide commenced in order to collect data as soon as possible. Before collecting data the intention for the study was constructed as to create a better understanding of how an integration process is executed within an acquisition. The reasoning behind choosing this specific case was due to the mergers and acquisition that occurred in December 2012, hence creating interesting and relevant data for interviews to be conducted on the specific subject.

The main collection of data have been conducted through interviews, different views from interviewees were composed together, more or less logically and deliberately into the context that maked sense of their interpretations. This study has used according to Bryman (2012) a purposive sample, which is a technique to strategically choose participants in order to use respondents that are relevant for the research question. The sample was executed with the researcher and gatekeeper at Alpha, where participants were chosen due to their geographical position, have been a manager throughout the acquisition and origin organisation, as these

were requirements that needed to be fulfilled in order to participate. Contacts with interviewees were initially through e-mail with a presentation of the study and thereafter respondents were contacted over telephone, if not possible an additional e-mail were sent, in order to decide date and time for the interview. Leave information in beforehand is a way to accomplish Vetenskapsrådet (2002) information requirement and utilisation regarding ethical considerations when conducting research.

All six regions are represented and an equal dispersion of managers between Alpha and Delta, only females are represented, as most care unit managers are females. Beside care unit managers, regional managers were selected because of changes in the organisational structure, which only are females due to the fact that regional managers are solely females. In total 19 interviews have been conducted with a total time of 810 minutes (see table 2), 15 interviews with care unit managers and 4 interviews with regional managers. All respondents are educated in healthcare and majority of respondents are nurses.

Moreover, after conducting interviews theoretical saturation was reached because all respondents discussed and talked about the same concepts but in different ways and contexts depending on how they perceive the discussed phenomena (Bryman, 2012). When starting to conduct interviews other relevant themes and concepts were presented. Therefore, the research intention has been reformulated and evolved over time within this process. The interviews were semi-structured with an interview guide, two different guides being used as a result of there being two different target groups. The reason for using semi-structured interviews was in order to control the conversation to make sure that focus was on the actual questions. All interviews took place in the respondent's workplace which is considered had a positive affect on generating a comfortable environment and a good conversation. Majority of respondents consent to record the interview, if not notes was taken, this helped to focus on the actual conversation and put focus on the respondent's body language. Focus on the body language is an important aspect to consider as it can reveal if the respondents are comfortable or not with the question asked (Bryman, 2012; Widerberg, 2002).

Respondent	Occupation	Date	Duration
Care unit managers X 15 Regional managers X 4	Majority nurses	February – March, 2014	Approx. 810 min in total

Table 2: Overview of interviews

After interviews were conducted work started to transcribe all material, and was done immediately with everything fresh in memory. 17 interviews were transcribed and the other two was not recorded, instead written notes were taken and those were transcribed in the same way. Transcribing the material was an enabler to go through everything accurate and resulted in a valuable overview of the studied phenomena. Quotations are used when presenting the result in order to strength interviewees' opinions (Hakim, 2000). The quotations used are from respondents in both Alpha and Delta, the reason for not revealing who says what is in order to enhance anonymity and is therefore instead named after numbers.

3.1 Analysing through grounded theory

Thereafter, started the process of analysing the empirical material. This study is based on an inductive approach, which implies to draw conclusion from empirical collected data. However, Thurén (2007) argues that using an inductive approach might result in that conclusions can never be one hundred percent as the result is presented from the collected material. However, as this is a case study Yin (2009) states that the studied phenomenon is only generalizable to its context and the goal are not to draw quantifiable conclusions. The method for analyse the material is based on grounded theory, which according to Martin and Turner (1986) is an agreeable method to use when analysing qualitative data. The concept of grounded theory comes from Glaser and Strauss (1967) publication. Further, the idea with grounded theory is that the researcher collects data and thereafter making general statements and then tries to generate relationships (Martin & Turner, 1986). After going through all transcribed material, coding of the material took place with different coloured pencils. From the material six different themes were discovered: *autonomy, the role as regional manager, identification, internal structure, knowledge sharing/cooperation* and *changes*. *Autonomy is about* how work is structured and that the care unit managers decide everything by themself. *The role as regional manager* deals with this new role that was created because of the acquisition and what it implies. *Identification* whether employees and care unit managers are identified with working tasks, the organisation or their own care unit. *Internal structure* deals with how work is structured and differences that exist within the regions. *Knowledge sharing/cooperation* is about how the different regions are working and cooperating. The theme *change* is related to the change that has occurred because of the acquisition. These different themes has been presented by the respondents in different ways and most of them are not related to the acquisition itself rather to be a manager within healthcare and as a base a profession within the healthcare industry. Thereafter the six themes have been divided in two main categories, *organisation of work* and *collaboration between care units*. Autonomy, internal structure and the role as regional manager compose the category organisation of work, the theme change is included in both categories and the two remaining themes identification and knowledge sharing/cooperation compose the category collaboration between care units. The motive to divide them is because these themes has common features and together creates better understanding for each other and the purpose of this thesis.

3.2 Trustworthiness

Provide research with trustworthiness is a criterion for how good the qualitative research is. Four criteria's should be considered, *credibility, transferability, dependability* and *confirmability.* The methodology regarding the different steps taken has been described in detail, the sample is presented, how the material have been conducted and analysed, which fulfils the requirement of *credibility* (Bryman, 2012). A weakness that can be stressed is that the study is based on a small number of respondents and cannot be taken as representative (Hakim, 2000). Awareness exists that a limited amount of interviews are collected, however, theoretical saturation was reached during interviews and collecting more interviews would not lead to another result, which the transferability criterion is highlighting. The main collection of data is collected through semi-structured interviews that have been recorded and transcribed, which fulfils the *dependability* requirement. Transcribing the collected material

enabled the researcher to be subjective when presenting the empirical material and this fulfils the *confirmability* criterion (Bryman, 2012).

4. Empirical results

4.1 Background

Alpha is one of Europe's leading companies within the private healthcare industry, has around 10.000 employees and is established in Sweden and four other countries in Europe. Through hospitals, specialist clinics and care units they offer a variety of medical, surgical and psychiatric healthcare with high quality. The headquarter is located in Gothenburg, Sweden. Alpha was established in 1994 and has expanded through several acquisitions over the years.

Sweden is the focus area that possesses hospitals, specialist clinics, psychiatry and proximity care. During this specific research proximity care is the target focus area and today operates at over 70 locations in Sweden, offering general medical and specialist healthcare in 12 county councils from north to south. The reason behind this choice is the acquisition that occurred in 2012. Alpha acquired one part of a healthcare company, Delta. This lead to that Alpha redoubled the volume of care units from around 30 to over 70 and the workforce, which are around 1800 employees. Through this acquisition listed patients also duplicated from 300 000 to 600 000. Changes also occurred in the organisational structure, proximity care in Sweden became divided into six regions: West, South West, South East, Middle, Stockholm North and Stockholm South. Alpha possesses a decentralised organisational structure.

4.2 Alpha Model

Alpha has formulated a business model that should be utilised worldwide, which is a way to control a decentralised organisation. The model is based on: *core values*, *healthcare with high quality* and *people are the essence to make a difference.*

The first part in the model, core values include three aspects, *quality, compassion* and *care.* Together they form a basis to achieve the best quality of life for their patients. The first aspect, *quality* is regarded for Alpha as the top priority and should never be compromised. Second aspect *compassion* implies to understand their patient's fears and vulnerabilities, to never forget the human aspect of healthcare. The last aspect *care* indicates to care for patients and employees in their daily work in relation to colleagues and Alpha.

The second part in the model, four cornerstones are created to deliver healthcare with high quality: *modern medicine, kind treatment, good information* and *nice environment and adequate equipment.* Together they create a solid base to deliver good healthcare. *Modern medicine* implies to always strive for new medical developments and an organisation that easily adapts to these new requirements. *Kind treatment* emphasises to focus on patient's perceptions and feelings about their illness, which is an important aspect to consider in order for the patient to have a sound recovery. *Good information* focuses on informing patients well, give information about diagnosis, treatment and progress. Lastly *nice environment and*

adequate equipment, giving a comfortable environment for patients to reduce treatment times and beside healthcare it is important to renew and develop IT systems.

Last and third part in the Alpha model is *people make the difference*. Professionalism is essential, however, it requires a culture and environment that strives for individual's to take responsibility, exercise authority and resources. The organisational structure is decentralised and employees working with patients such as physicians and nurses initiate developments, which enables Alpha to continuously work and improve the healthcare processes. Other functions in the organisation are support functions to provide its members with necessary support in order to take care of their patients in best possible way.

The Alpha model is a tool to structure a decentralised organisation. During interviews the model were discussed and the importance of quality was raised; quality is a factor that never can be compromised. Provide patients with high quality care and treatment is Alphas obligation and responsibility. However, the model is according to interviewees nothing unique for them, rather how healthcare in Sweden should be operated. According to respondents what differs Alpha from other healthcare actors is their decentralised organisation, with acting space for care unit managers. The decentralised organisation is emphasised and something that was expressed as valuable during interviews. Difficulties existed to explain the entire model, interviewees rather focused on introducing the importance of acting and decision space. The part regarding quality was taken for granted as practicing healthcare. This further leads into organisation of work that supplementary will be emphasised.

4.3 Organisation of work

4.3.1 The role as care unit manager

Alphas work is decentralised, which implies that care unit managers are in charge of their own unit, make their own decisions and are responsible for the financial, human resources, marketing, and purchasing aspects. Beside the administrative responsibilities they are in charge to fulfil medical requirements and patient quality. To assist them different support functions exists such as controller, human resources, IT, marketing and a medical practitioner manager if not the care unit manager are a practitioner him/herself. Moreover the care unit manager reports to the regional manager, however, according to the job description the regional manager are not regarded as a support function.

> What I have understand so far during this year, Alpha wants the care unit manager to make all the decisions, and I am responsible for everything and should be in control, which is impossible. I believe if we have a controller that do some of the work, it wont lead to that I am not informed, but maybe it is the right person doing the right things.
>
> - Care Unit Manager 10

The care unit managers appreciate having a lot of responsibility. However, some respondents believe their role sometimes is lonely. If the care unit is profitable with a good financial result, limited interaction from support functions and regional managers takes place compared to if

not achieving a good financial result a lot of involvement is given from support functions and regional manager. Care unit manager's stresses the importance to meet the regional managers solely even though nothing special has occurred.

> We ask for help when we need it and most support we need is from salary or human resources. Otherwise we take care of ourselves, and we want to do that. It´s our way of working here, but if we need help they help us.
>
> - Care Unit Manager 6

How the care unit managers are structuring their care units differs. The care unit manager is in charge of the care unit; beside this function some have an assistant while other do not. On Alphas web site, different functions, titles and roles are used beside the care unit manager, such as head and assistant head of unit manager and administrative assistant. These roles are not related to a specific region, differences also exist within the same region as well as between Alpha and Delta. However, it is more common that care units in one region have an assistant care unit manager than in others.

When care unit managers from Delta entered Alpha, followed a process of learning all new IT systems, which were perceived differently. Education to learn the new systems has mainly been in-group and thereafter care unit managers are expected to handle it, which have been and is still difficult. Main support afterwards has been over phone and care unit managers from Delta express that more support is needed in a real life context.

Care unit managers are facing several similarities as they have the same position. However, one problem that has been discussed with several respondents is the recruitment of general practitioners, which is or has been problematic for several regions. Respondents from one region express that they are in need of more general practitioners. For the moment the care unit manager cannot find suitable general practitioners to recruit, instead he/she needs to hire a general practitioner through a consultancy firm. This is very costly, has a negative impact on the business result and is only a temporary solution. Another scenario care unit managers are facing is when a suitable general practitioner is located and should be employed. Due to the fact that general practitioners are scarce resources it is common that this person have been employed at another care unit in the same region. In this case care unit managers are sending e-mail to each other to control whether this person have been employed and receive recommendations. When the general practitioner is applying for a job he/she has often applied for a job at another care unit in the same region and is trying to push for a higher salary. Care unit manager are aiming to prevent this by sending e-mails to each other and asks if this person has applied for a job and initial salary, to make sure they are positioned on the same level. In all those scenarios care unit manager needs to deal with the problem in lack of support from the regional manager and human resources, which generates a feeling of loneliness and incapability of handling the situation. The care unit is not working without general practitioners and therefore the care unit manager needs to use agency workers even though it is not preferable due to the expense.

The organisational structure is more comprehensible according to some regions after reduplication of the company, it is explicit that the care unit managers are in charge of their own unit with given guidelines. In the past some regions have aimed to work similar but it is difficult as all care units are offering different healthcare, some specialist care while other do not.

4.3.2 The role as regional manager

For each region a manager is elected who is in charge for around 12 care units. Besides the regional manager a controller and medical practitioner are elected. The regional managers must rely on that the care unit manager has the right capabilities to run their own care unit. Most of the regional managers have before worked as care unit managers. Their role as regional manager include to have a close dialog with care unit managers, support and initiate changes, responsible for policy and guidelines for protection of patients, deviation handling and implementation of new care units.

The role as regional manager is perceived challenging because they are a middle manager, with no mandate to control the different units. The regional managers are still not certain if they have a financial responsibility or not, some of them believe they do while other do not. The care unit managers wont let the regional managers interact in their work especially from Alpha, because they are afraid of being controlled and or someone will discover their mistakes. However, care unit managers from Alpha are not used to have a regional manager while Deltas organisational structure was similar to how Alpha is organised today. In Delta the regional manager had control and was managing the different units, for example if new general practitioners were hired the regional manager was approving in beforehand. While Alphas regional manager only should support the care unit managers and they express that their function should be of supportive character.

> The care unit managers decide by themself and we cannot force them to anything. However, if the commitment not is operated properly we need to act.
>
> - Regional Manager 4

During the first year regional managers have not received a job description, which they emphasise is of importance for them to have something to rely on, in order to justify their work. The regional managers have been facing a lot of difficulties because level of care unit managers has varied, in some regions the manager have spent plenty of time in one or two care units which means that other has not got their attention and support.

The different regions are working in different ways. One regional manager together with the financial controller is visiting the care unit once a month, if needed. Otherwise meeting the three of them is taking place every other month, beside the monthly regional meetings. Another regional manager has divided the region in two parts and meetings occur in the smaller group and less frequently the whole region is gathering. Common for all regions is their regional meeting with all care unit managers once a month or with six weeks in between. Structure on those meetings differs, however, care unit managers emphasise that those meetings are based on information about latest news from the regional manager.

4.4 Collaboration between care units

Interaction between care unit managers and regional managers is diverse; on the one hand no contact except from the regional meetings and on the other hand level of interaction is more frequent, phone calls and meetings occur between the regional meetings. Level of interaction is also influenced on where in the region the care unit is located; far away from the regional manager interaction is limited and vice versa. Other regions perceive level of interaction as unchanged.

Collaboration within the region is also diverse, some are working closer together and helping each other and wish to continue, for example sharing nurses between care units while others are working solely. Before entering Alpha care unit managers in Delta describe that more collaboration took place persistent by sharing good and bad examples especially related to problematic human resource questions during regional meetings. Pursuant to Delta, Alpha is not familiar with this, however, something that is perceived as valuable and knowledgeable as all care unit managers are facing the same subjects. Another valuable aspect to add for their regional meetings is that support functions should participate recurrently in order to create understanding, build relationships and participation for each other's work.

Reduplication of the company has resulted in more individualistic work, limited collaboration occurs even though enjoying each other's company during regional meetings. Other emphasise that the most important aspect to consider is their own care unit and its result rather than Alphas overall accomplishment. Anyhow, collaboration is requested from care unit managers and wants further of that in the future. For the moment the regional manager is not initiating collaboration, however, promoting it for care unit managers to create. Several things need to be done at the same time in absence of time and consequently care unit managers do not consider spending more time to collaborate or attend at meetings.

Alpha are the owner of the care units and the care unit managers believes that he/she is identified by Alpha, which is considered natural as they have more relationships within the organisation and sense that they are part of a bigger entity. Initiatives to create relationship between the different care units have not been taken from the business area management team. Generating relationships would been valuable for employees and something that care unit manager assumed they should arrange.

4.4.1 Collaboration with support functions

Level of interaction between support functions and care units differs. On the one hand, no interaction takes places with administrative employees from support functions, those personnel have visited the care unit a few times, for example to educate the care unit manager in a finance system. On the other hand, a well-functioned interaction and employees from different support functions are helpful and aiming to support and assist the care unit managers with quality. Even though interaction occurs care unit managers have not met majority of administrative employees from support functions in a real-life context, which is negative. Would be valuable to establish relationship with those colleagues in order to build better understanding for each other's work.

> I have some persons that are trustworthy but I still only knew a few and it is still ah, is this girl that are doing this for us? It has gone a year and perhaps it needs to take time.
>
> - Care Unit Manager 4

> Very good service, always pleasant and positive even though you are calling for the seventh hundred times and asking the same question because I still don't understand and they are still service-minded.
>
> - Care Unit Manager 1

Level of interaction from support functions are also described as unchanged, care unit managers receive the interaction needed, in some cases they have more visits from example the payroll department, which helps them with job scheduling, which they believe is positive. Due to the reduplication of care units the support functions has expanded and an example is the payroll department that has more resources and are answering e-mail much faster. In some cases respondents express that a negative aspect is the received interaction from support functions. Limited help is given; nowadays they need to do more by themselves, which is considered difficult.

> The marketing department used to help us write job advertisement and now we need to do it alone and I think it is difficult because I am not educated in writing catchy advertisements.
>
> - Care Unit Manager 2

More work is delegated to the care unit managers, which is not appreciated. Being a care unit manager is difficult because several different working tasks need to be controlled. If not receiving good level of interaction the work is perceived by the respondents as to demanding and won't be manageable. Even though more responsibility is delegated to care unit managers, however, at the same time the responsibility is two-edged. It is still important to decide what kind of advertisement the care unit wants to use that is related to that specific region and nothing that is decided on central level.

5. Discussion

This study set out to explore how care unit managers are responding to different demands. Alpha acquired Delta and changes occurred in their organisational structure, Alpha was divided into different regions. Alpha is emphasising a decentralised organisational structure, with acting space for care unit managers whom are responsible for deliver high quality care and responsibilities of being a manager. This leads further into elaborating upon the theoretical framework and empirical result and will stress how multiple demands can be expressed. Towards additionally emphasise on competing and coexisting demands to end with how individuals are identified with the existing differences.

In this case two logics occur, healthcare and administration. The logic of healthcare can be seen as a manifestation of the logic of professionalism and administration can be seen as a manifestation of the logic of management. The reason for labelling them like this is because they are more suitable in this context according to the author. Individually the logics are providing formal and informal rules of action, collaboration and interpretation that guide and restrain decision makers (Reay & Hinings, 2009). The multiple logics can as expressed be seen as a cognitive map with a common belief system for its participants to guide and give meaning to their activities (Scott, et al, 2000).

The logic of healthcare accentuates to care and treat patients in best possible way. Patient safety and medical requirements is important to ensure. Quality is the essences in the logic of healthcare (Blomgren & Sundén, 2008) and has a pure focus on treatment and care for patients (Reay & Hinings, 2009). General practitioners determine the importance of quality, where focus on quality is a factor to create patient commitment towards the general practitioner and in the end for the workplace where the general practitioner is practicing healthcare (Scott, et al, 2000). The Alpha model is pervaded with focus on quality in all different parts. The importance of quality is not according to interviewees unique for Alpha, rather how healthcare in Sweden should be generally practiced.

Education is influencing an individual because norms are created in that specific context and will generate patterns of behaviour (Goodrick & Reay, 2011), and will follow and guide the individual into the future (Pache & Santos, 2013). In this case the dominant logic is healthcare, where norms, values and practices are created during education and templates produced, which in the future is used as tools to gain legitimacy in their careers. Work can be regarded as homogenous because norms, routines and values are inherited and transmitted. This is manifested because all respondents have an educational background in healthcare and majority are educated as nurses. However, when entering an organisation a new logic is generated because organisations consist and justify work with goals (Pache & Santos, 2013), values and practices, which is shared in that unique context (McPherson & Sauder, 2013).

The logic of administration implies to focus on business, with emphasise on economy. Cost-effective work with focus on always strive to increase efficiency. Manage work with the mantra, do more with less (Reay & Hinings, 2009). Working in the administrative logic within healthcare entails to work with strategic planning, reallocate service packages and categorise cost centres. This implies to adopt and create new organising principles, with a pure focus on strategic management rather than operational management. Increase efficiency and allocate resources in best possible way with a conviction of cost consciousness (Scott, et al, 2000). Care unit managers need to allocate resources in order to manage a care unit with both efficiency and profitability. How the care units are operating differs depending on how the care unit manager has decided to structure work. In some care units the care unit manager has one or several assistants to ease workload while others do not structure work in the same manner. The care unit managers decide individually what they regard as most efficient and cost-effective. This implies that the care unit managers are performing different levels of administrative work.

In this case two logics exist, healthcare and administration. Education in healthcare has provided norms, rules and practices that are deeply inherited and transmitted in daily work (Goodrick & Reay, 2011). Entering an organisation has also provided the individual with a new logic (Pache & Santos, 2010) where norms, rules and goals are shared. How the different logics are coexisting and competing against each other will be further be emphasised.

5.1 Competing and Coexisting Logics

Working as a care unit manager in healthcare implies having two logics that coexist and compete simultaneously, which have been manifested before. The logic of healthcare should contain high quality care and the logic of administration deals with increase efficiency, allocate resources and execute changes.

Two logics are coexisting and competing each other. When a new logic enters an organisational field, rivalry among actors often take place because the new logic challenges actors from the given logic (Reay & Hinings, 2009). Healthcare is the given logic as the care unit managers have been provided with formal education that has given shared norms, beliefs and values. When the new logic has been introduced to a given field, it challenges the existing one and current actors may not be able to decide a winner and a loser. In this case, neither healthcare nor administration could win the battle. Due to reasons for they are interdependent of each other, changes in an organisation can occur through collaborations that encourage autonomy and individual actors. The competing interest of actors can connect to coexisting logics that have suffered through collaborative actions (Reay & Hinings, 2009). An example within this case is the situation care unit managers are facing during recruiting general practitioners. General practitioners are regarded as scarce resources and care unit manager have difficulties in finding suitable candidates to hire and are using agency workers as a solution. On the one hand, this solution is used to operate the care unit with high quality, and on the other hand it is not preferable due to the expense. However, in this situation care unit manager are using agency workers to solve the situation, and act correctly according to the logic of healthcare while the logic of administration is suffer. This implies that several logics exist on the field, how they are utilised depends on the situation and what is required. Actors within a field can use a given logic to influence decision, justify activities or change and in another situation use that logic differently (Lok, 2010; McPherson & Sauder, 2013). Actors interest, believes and preferences determines how the logic is constructed, submitted and utilised, which implies that logics are an individual established perception (McPherson & Sauder, 2013).

Care unit managers who originally comes from Alpha are facing too many things simultaneously in absence of interaction from example the marketing department, work tasks have been delegated after the acquisition to the care unit manager themselves, for example writing job advertisements. This change is also affecting the logic of administration. While care unit managers from Delta are not habituated towards being in charge of everything individually and manage all decisions. However, these two different scenarios are describing how administrative responsibilities are affecting the care unit manager's work. Care unit managers are facing a dual logic, identified with the title hence only familiar with required responsibilities and are responding with compartmentalisation and depending on time, space

and situation the individual display different responses depending on its most favourable outcome (Pache & Santos, 2013). Reacting with compartmentalisation (Pache & Santos, 2013) can also be regarded as a way to emphasise on segmentation. Competitive logics can coexist and no decision needed of whom should success, rather view the competition as a solution on meeting professional and organisational requirements (Goodrick & Reay, 2011).

Care unit managers are exposed to several competing logics at the same time, which can cause conflicts for its members (Pache & Santos, 2013). Beside the administrative logic the care unit manager also needs to deal with the logic of healthcare, which sometimes can contradict or challenge the logic of administration. One part of the Alpha model stresses the importance of deliver healthcare with high quality, however if the financial result not is obtained, how does it influence on quality and are those two possible to combine. An example that can be given is when care unit managers are recruiting general practitioners; in this situation it is not possible to combine the two logics. Multiple logics that coexist and compete are related differently dependent on the organisation and the individual (Goodrick & Reay, 2011). In this case care unit managers should not view logics separately, rather as something than can guide and be a key factor to meet requirements from both logics. Multiple logics exists in this case, thus logics are competing and coexisting each other simultaneously. Care unit managers are acknowledging both logics, hence self-identity decides how the identification is expressed. A new logic can generate contradictions and in parallel produce reinforcements of the old logic (Swan, et al, 2010). Care unit manager's old logic is in this case, healthcare. Education has provided templates for future work, and entering an organisation results in a new logic that is competing the old logic. In this scenario competition between the logics occur, the logic of administration is reinforcing the logic of healthcare. Lindberg (2014) stresses the need to understand that multiple logics can be combined, however, how they are utilised depends on the context, nevertheless the multiple logics constantly creates a new collection with procedures. In this thesis it is manifested in for example never compromise on quality to achieve budget goals. Requirements in the logic of healthcare are being dominant because of competition occur from the logic of administration. Recruiting a general practitioner through an agency firm is supporting the logic of healthcare while the logic of administration is suffering due to the expense.

The administrative logic is rather based on autonomy and no formal education is given instead informal training has been provided (Reay & Hinings, 2009; Scott, et al, 2000). This implies that the care unit manager possess great influence to organise work after what he/she believe is suitable. Self-identity is deciding the outcome of actions (Lok, 2010). Support functions exist to support care unit managers, however, important to stress is that care unit manager takes the final decisions and support functions and regional manager cannot cross the line to make the final call in any situation. Nevertheless, if the financial result is negative the regional manager needs to act otherwise care unit managers are in charge. When the regional manager acts the problem already exist. For the moment care unit managers do not want the regional manager to be involved because they are afraid they have done something wrong. The Alpha model stresses professionalism, individuals to take responsibility, exercise authority and resources; this is what constitutes the organisational culture. Work is rather of

heterogeneous character. Having autonomy entails reactions with compartmentalisation, displaying loyalty towards one logic in a given settings and displaying rejection in another (Pache & Santos, 2013).

This stresses that autonomy is two-edged depending on the situation, recruiting general practitioners is regarded as difficult and lack of support from regional manager and human resources, while be in charge of advertisement is positive as care unit managers knows what is important in that specific region. In a scenario like this loyalty and identification is given the logic when it suits the care unit manager's self-interest. This scenario is aiming for autonomy, adopting practices that are more favourable in different contexts and using them to distance self-identity and preserving autonomy (Lok, 2010).

5.2 Identification

The way the care unit managers decided to describe their position is a way to possess status, power and mandate and is identified with it. The title is acquainted for them and awareness exists in what to do, how to do and perform to its settings. Feelings of self-realisation, legitimacy and completeness (Pache & Santos, 2013) might occur due to the fact that being more than only providing healthcare as a nurse, instead climbing several steps higher in the organisation. In this situation multiple logics occurs and creates conflicts for its members (Dunn & Jones, 2010; Greenwood, et al, 2011). The title care unit manager contains, as previously presented two logics, healthcare and administration. This implies that the care unit manager must be in control of all parts in their unit, including healthcare with focus on medical requirement and patient quality and administration with focus on financial result, human resources and marketing, to only mention a few.

The individual may not relate of equal salience towards the multiple logics, how the logics influence the individual differs (McPherson & Sauder, 2013). How the individual react upon the logic can be explained from the concept of availability, accessibility and activation. All of them refer to knowledge and information, what differs them is the degree of relationship. Availability refers to what an individual have, accessibility what comes to mind and activation refers to how it is utilised in social interactions. Novice, familiar and identified is different degrees of how available, accessible and activated an individual is towards logics. How the different degrees are utilised can be seen as different steps on a continuum (Pache & Santos, 2013).

Care unit managers from Delta were after the acquisition took place novice about Alpha as an employer. They had limited knowledge and information about them and had not been socialised in their context. Progressively socialising occurred with knowledge and information about Alpha when for example participate at regional meetings and when the business area manager and assistant business area manager visited the care units. The logic of healthcare is care unit managers from Delta describing as unchanged, the assignment of providing healthcare with high quality were the same in Delta as it currently is in Alpha. This implies that they are identified with the logic, knowledge exists and utilised in social interactions (Pache & Santos, 2013). The same perception exist among care unit managers originally from Alpha, the logic of healthcare is unchanged, they are consequently still

identified with this logic, they know what to do and who they are in the setting and how they are related to it's surrounding (Pache & Santos, 2013). All interviewees reflect upon the logic of healthcare as their main obligation and responsibility. Nothing that is unique for Alpha as an employer, rather how healthcare should be operated in Sweden.

The logic of administration in Delta was structured differently, which implies that the new logic of administration are competing and challenging the old one. Greatest change for care unit manager in Delta is that they are in charge of their unit; they do not for example need to ask for permission about hiring a new general practitioner and are also fully responsible for the financial result. Majority of care unit managers have not met support functions that help them on daily basis with for example financial and human resource questions. This is something that care unit managers accentuate is of importance to create mutual understanding for each other's work. Towards this logic care unit managers are familiar, knowledge is available not accessible. No strong links are created towards the logic, and the logic is rather used as a way to fulfil requested demands and gain legitimacy (Pache & Santos, 2013). In this situation the individual is preserving autonomy and distance self-identity to use practices with most favourable outcome (Lok, 2010).

Care unit managers that originated from Alpha are also experience that the logic of administration is changed due to the acquisition and they were before the changes identified with it. Instead care unit managers from Alpha are reporting to the regional manager rather than to the business area manager as before the acquisition. This has been presented by care unit managers in Alpha as a feeling of being supervised and controlled. Towards the organisational structure care unit managers from Alpha are experiencing hybrid adherence for the logic, both novice and familiar. Novice because of the way Alpha is organised, before the acquisition they had more autonomy and afterwards has generated less autonomy and more control due to existence of regional managers. For the moment care unit managers are not loyal the logic and do not want to change their behaviour for the new context and are applying ignorance, resisting the logic (Pache & Santos, 2013). Instead they are excluding the regional manager and do not want them to be involved in their work because they are afraid that someone will correct them which could result in disciplinary sanctions. However, care unit managers need to gain legitimacy in order to perform their work properly, the level of adherence differs. In some contexts they are familiar and in other contexts novice. In this situation care unit managers are reacting with compliance, the competing logic are challenging the taken for granted logic and the individual needs to adopt compliance with the agreed given logic (Pache & Santos, 2013). The new logic must not lead to a consistent and unified identification; the identification process is rather hybrid, some demands are responding to self-identity while others demands creates a new logic (Lok, 2010). In this case care unit managers are showing familiarisation with the logic to be legitimate and concurrently engage in opportunistic contradictory practices.

Even though all care unit managers are identified with the title as care unit manager, the responsibility the role implies can be perceived as lonely, difficult and unmanageable. Preferably the logic of administration is familiar rather than identified. Knowledge and information is available and the individual understand the demands the logic is requiring

(Pache & Santos, 2013). This implies that care unit managers not are identified with the responsibility the title contains. They are struggling as mentioned previously in finding general practitioners to recruit, this situation is problematic in several regions. Interviewees express that they do not receive enough support from the regional manager and human resources, which generates a feeling of insufficiency. The solution today is to use an agency firm that is expensive and negative for the care unit's business result. The perception is regardless if the care unit manager origins from Alpha or Delta. In situations like this dual logics exist and employees are taking and utilising everything that are benefiting them. In order to run the care unit they need an organisation behind them, to assist and support them. On the other hand, they do not want to be too influenced by that organisation, they rather want to do what is best for them in their own way without interference. The care unit managers are legitimating their actions by producing parts and generate templates to legitimate existing actions that contradict the new logics. Basically the care unit managers are translating practices that are associated with Alphas overall accomplishment, that are supporting their own self-identification in order to promote their own given logic (Lok, 2010).

Another factor that might impact the degree of adherence towards the logic of administration for all care unit managers is how the different care units are structured. Differences exist between the different regions as well as within one region. If having a well-structured care unit with administrative assistants whom unburdens the care unit manager, could instead lead to that the they can focus on its actual task: control, supervise and delegate working tasks. This could lead to that the care unit manager is more identified with its position as having more control and know how to relate to its surrounding (Pache & Santos, 2013). If not having a well-structured care unit burden is superior for care unit managers, not having trustworthy employees to ease work implies to deal with everything on their own. Alpha does not seem to have a chart for how the care units are suppose to organise work, beside that the care unit manager is in charge. Thereafter it is up to the care unit manager to structure work as long as it is economically beneficial. This result in that care unit manager is more identified towards the title and familiar with its requirements (Pache & Santos, 2013).

6. Conclusion

This study aims to explore how managers in healthcare are responding to different demands. In this thesis two logics coexist and challenges each other simultaneously, healthcare and administration.

The first research question that was formulated was how care unit managers act upon different demands. This study contributes in highlighting the understanding for that even though logics are coexisting and thus also competing against each other, the logic of healthcare will always be top priority as work regards to deliver high quality care for patients. The logic of healthcare is deeply rooted through education with norms and templates in order to legitimate actions in the future career. Constantly the logic of administration exists, if for example a care unit is in great need of a general practitioner and the only option to solve it is through an agency firm, the care unit manager would act as accordant even though it has a negative impact on the financial result. The contribution to the literature in this thesis is that logics do

coexist and compete against each other, and one logic must not compromise the second logic. It is rather that some situations require different needs and one logic might need to suffer in order to accomplish and fulfil demands of another logic. Nevertheless it would be valuable to study another occupation for example teachers, which are facing multiple logics and how they are relating to the differences that occur.

The second research question that was formulated was how are care unit managers identified with different demands. The two logics coexist concurrently, however the logic of healthcare has been stabile over time, nothing has affected how the interviewees are identified towards this logic, as the assignment and patients is the same hence it doesn't matter that an acquisition has occurred. The logic of administration is however in constant change depending on situation and requirements, not a single situation has been exposed where the care unit managers are fully identified towards the logic of administration, only one part a time depending on the care unit manager's self-interest. Another contribution this thesis is given is understanding on the identification process towards multiple logics. The identification process is an important aspect to consider when multiple logics coexist and challenges each other simultaneously. The reasons for its importance in this thesis are due to ease work burden and achieve a more manageable role. Focusing on establishing better relationships between care unit managers and regional managers, with the intention of creating mutual understanding and support. Support functions must also be more visible for care unit managers and be more accessary in their work because those individuals are supposed to simplify, support and contribute at the care units. Achieve identification towards multiple logics, collaboration is an important aspect that should not be disregarded.

6.1 Practical implications

Practical implications have been identified to strengthen the care unit manager's position in Alpha. Regional managers are supposed to assist the care unit manager during recruitment processes if the care unit manager wishes according to the job description for regional managers. According to the job description for care unit managers, human resources should assist and a medical physician manager when recruiting general practitioners, nothing is mentioned about the regional manager. As this case has stressed care unit managers are dealing with the recruitment process by themselves and is not receiving enough support. The reason for not asking for help is because they are suppose to deal with it individually, something the Alpha model stresses, professionalism and autonomy. Asking for help can be regarded as a sign of weakness and an incapable care unit manager who cannot manage his/her unit. Care unit managers are struggling during recruiting general practitioners, lack of finding suitable candidates and when obtained a candidate, that general practitioner has applied for job at several care units at the same time and aiming to raise their salary. In this situation a solution would be if it existed a central instance that helped the care unit manager in the recruitment processes. This person, from a human resource department, would collect suitable candidates and knowledge exists whether this person has applied at several care units in parallel and can also support the care unit manager with for example the first screening process, interviews and collect references. The Alpha model emphasise importance of quality, this solution is a way to push for higher quality internally at Alpha.

Collaboration with colleagues within the region can generate a working climate that allows discussion about problematic questions or successful achievements that have been accomplished. Even though care unit managers do not believe they have time for attending at meetings the return on attending will generate knowledge and strength relationship for the future. The regional meetings should proceed as it is, important to note is that support functions should be invited to attend, to talk about their work and understand the work of care unit managers. Establish relationship and collaboration between care unit managers and support functions are a way to facilitate support and assistant in care unit manager's daily work. Another relationship that needs to be strengthening is the regional managers and care unit managers, if creating a good atmosphere with regularly informal meetings would generate trustworthiness and care unit managers would ask for help before the situation is chaos and the regional manager must act. The practical implications that have been given can result in a changed relationship towards the logic of administration for care unit managers. Hopefully the logic of administration will in the future generate a complete identification. The different levels of relationship should be seen as different steps on a continuum, begins with being novice, to continue with being familiar to end up with being identified (Pache & Santos, 2013). According to Lok (2010) the most powerful tools to influencing an individuals behaviour is through influence the identification process towards the logic and its affiliated practices.

This study has only been explored a case when two coexisting and competing institutional logics exist. The scope of the study would be broaden by emphasise in adding the perspective of support functions to find out their opinion about the administrative logic in order to expand the result. This study has used a qualitative approach based on interviews and secondary data, an interesting aspect to add is to accomplish observations in care unit managers daily work as a way to broaden understanding of the two coexisting and competing logics. The target area in this study has been Alpha and proximity care in Sweden, to further broaden this study it would be valuable to compare private healthcare companies towards the public sector and find out whether similarities and differences exists and how they are expressed. Two multiple logics has been studied and an additional contribution to further research is to add a third logic to elaborate what impact it has.

7. References

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