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The Unexpected Role of Materiality in Strategic Implementation

A case study of value based care

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Abstract

In this article we dedicate attention to how a general strategy as Value Based Care (VBC), is implemented and legitimated in a local context. The aim of this study is to contribute to further understandings of the dynamics in institutional work, with regards to both humans and materials, when a new strategy is implemented. To gain understanding in this, we undertook a qualitative research method, including interviews, semi-structured observations, and document analysis. First of all, we detected that an essential part of the strategy of VBC has been materialized, and by using theories of institutional work and materiality, we have been able to identify that both humans and material objects participate in the institutional work in the initial phase of the implementation. This study shows that humans and materials collaborate in the creation of institutions, and that the dynamics of materiality can result in different effects on institutional work, more specifically, reinforcing effects, and hampering effects. Further, we argue that a deeper understanding of these roles, and an extended collaboration between these actors, can overcome several of the difficulties that may occur in initial phase of an implementation of a new strategic management model. Finally, this article emphasize that a strategic implementation, that succeeds to create reinforcing effects of materiality, is more likely to become successful.

Keywords

Value Based Care, strategic implementation, institutional work, materiality, mimicry, construction of networks, theorizing

Introduction

Value Based Care (VBC), has during the past years been in the center of the debate regarding the Swedish healthcare (Akner et al. 2014, Akner et al. 2015, Fölster & Nordenström 2015, Nordenström 2014), and currently it constitutes a frequent occurring management model, which is implemented at several hospitals in Sweden (Svens 2015). The founders of VBC, is the American management guru Michael Porter and Elizabeth Teisberg, and they mean that VBC is the new strategy to overcome current issues existing in healthcare sectors worldwide (Agerberg 2014, Porter 2010, Porter & Teisberg 2006), thus also in Sweden. During the past

decades, the Swedish healthcare has tried several organizational strategies and management models in order to overcome existing challenges in the healthcare sector, but without any major success (Berlin & Kastberg 2011, Hallin & Siverbo 2003, Porter & Lee 2013). Still, the Swedish healthcare struggles with rising costs, long waiting times, and uneven quality (Berlin & Kastberg 2011, Hallin & Siverbo 2003). Previously, the Swedish healthcare has been characterized by using supply-driven strategies, focusing on costs and processes (Porter & Lee 2013), hence VBC aims to bring focus back to the patient, and highlight the importance of measuring the whole healthcare cycle, and not only isolated engagement of healthcare professionals (Porter 2009). Porter suggests that value shall be defined as the health outcomes achieved per dollar spent, and states that this definition of value also encompasses efficiency (Porter & Teisberg 2006, Porter 2010).

Although, the Swedish healthcare is demanding a new organizational innovation to overcome the challenges, which previous management models have not been able to solve, the strategy of VBC has been loudly criticized by both researchers and healthcare professionals. Critique regarding the meaning of value has emerged, and people are questioning the effects of an American healthcare model in the Swedish healthcare system. Most of the critique is however directed towards the difficulties of measuring and defining value, because of its subjectivity (Akner et al. 2014, Akner et al. 2015). As an example, Akner et al. (2015) are questioning, how to measure quality in a meeting where a cancer diagnosis is delivered? Or how to measure value in a dialogue between a physician and a patient's relatives? Although Porter states that value shall neither be seen as "an abstract ideal nor a code word for cost reductions" (Porter 2010, pp. 2477), it is exactly what the sceptical voices highlight. Researchers argue that the strategy of VBC is just a modified version of the previous criticized model New Public Management (NPM), which focus has been on processes and cost reductions (Akner et al. 2015).

However, major actors in the Swedish healthcare sector have now invested a lot of resources in implementing the strategy of VBC (Aspelin et al. 2015), and hospitals' management put great faith into the strategy. In order to implement VBC successfully, it is of great importance to anchor the strategy into the local context, since it is the local healthcare professionals who create value for the patients, and who perform the basis of the strategy (Nordenström 2014, Porter & Lee 2013). By implementing new strategies and new management models, specific issues is supposed to be overcome, but previous studies show that it is difficult to fully anchor these strategies into practice, and that previous attempts within the Swedish healthcare has usually been regarded as classic examples of market failures (Berlin & Kastberg 2011). It is highlighted by several studies, that the healthcare sector is an especially difficult organization to control, and that new management models have slightly impacts in practice due to the organizational complexity, and because of the high institutional character of healthcare organizations (Berlin & Kastberg 2011, Scott 2000). Berlin and Kastberg (2011), specify additional reasons for why the healthcare sector is hard to control. For instance, the healthcare sector constitutes of many interdependencies that makes it hard to fulfill change, and further, most people in the healthcare sector, work in accordance to their professional logics instead of in accordance to intentions of a management model. Moreover, recent studies argue, that management concepts within the Swedish healthcare, tend to come as trends, which last for approximately three to five years,

but thereafter is replaced by another concept or model (Fredriksson et al. 2015). There are researchers who believe that the strategy of VBC also may become abandoned if not the understanding of, and the reflection upon, the strategy are extended (Svens 2015). Porter (2010), stresses that a shift in focus from volume to patient value is a great challenge, but argues that the Swedish healthcare has the preconditions to be in the front line of this strategic development.

The complexity of implementing strategies and controlling models in healthcare systems has been highlighted and investigated by many researchers before (Berlin & Kastberg 2011, Bååthe & Norbäck 2013, Hallin 2000, McNulty & Ferlie 2004), and some researchers have also questioned whether it is even possible to succeed with such extensive implementation (McNulty & Ferlie 2004). However, it is still a less-explored mystery of what triggers changes in a highly institutional organization, and what determines if a new strategy is getting anchored into a local contexts or not, and therefore this paper is dedicated to this research area.

In order to understand what actually happens in practice, and to explore how institutions are affected in local contexts when a new strategy is introduced, an institutional work perspective will be undertaken (Lawrence et al. 2013, Lawrence et al. 2009). Using theories of institutional work, provide a practice-based dimension to institutional theories, and it helps us to understand the purposeful work, undertaken by actors, in order to shape organizational life (Lawrence et al. 2013, Monteiro & Nicolini 2014). Until recently, the research within this field have been focusing on the role of humans in institutional work (Dacin et al. 2002, Reay & Hinings 2005, Suddaby 2010), however, researchers are now asking for a new dimension, where the role of materiality also is included (Jones & Massa 2013, Lawrence and Suddaby 2006, Lawrence et al. 2013, Monteiro & Nicolini 2014, Nicolini et al. 2012, Raviola & Norbäck 2013). Hence, it is advantageous to include this in our study, to capture the micro-level processes between actors (Lawrence and Suddaby 2006), that practically takes place in the local context during a strategic implementation.

The aim of this study is to contribute to further understandings of the dynamics in institutional work, with regards to both humans and materiality, when a new strategy, such as VBC, is implemented in an already established organization. The research question to be answered in this study is; how can we understand the implementation of a new strategic management model (VBC) from an institutional work perspective?

To meet the aim of this article, our study is set up at a healthcare clinic at one of the major hospitals in Sweden, which currently is implementing the strategy of VBC. This clinic will further in the article be referred to as “The Clinic”, and it has functioned as a pilot project in the implementation of VBC. It is interesting to study this specific clinic, since the implementation of VBC has been argued to deliver positive results at The Clinic, and it has been seen as a successful project by the hospital management. Due to the successful results of this work, The Clinic has been nominated to the prize for the most successful development project within the Swedish public service, and it has also been awarded with the quality prize of the University hospital. Thus, this case enables us to study an organization, with already established institutions, that currently are in a process where institutions may be affected.

Following distribution of this article will be to first review previous research within the field of institutional work, more specifically the work of theorizing, mimicry and

constructions of networks, and thereafter introduce materiality in institutional work. Further, the methodology used to collect and analyze our data is submitted, and our case is presented in more detail. Next, we present and follow up with our analysis and discussion, and finally, the concluding remarks and the contributions of our study are summarized.

The Work of Creating Institutions

Even though institutional theories have been a topic for organizational research in several decades, its focus has shifted during time (Arman et al 2014, Barley & Tolbert 1997, Battilana et al. 2009, Dacin et al. 1999, Dacin et al. 2002, Dimaggio & Powell 1983, Granovetter 1985, Reay & Hinings 2005, Reay et al 2006, Suddaby 2010). A rather new type of studies, have attempted to extend previous institutional theories by exploring how the two main paths in the theory can be unified and understood in combination (Lawrence & Suddaby 2006, Lawrence et al. 2009, Lawrence et al. 2011, Monteiro & Nicolini 2014). More specifically, by understanding both the maintenance (Dimaggio & Powell 1983, Granovetter 1985) and the transformation of institutions (Dacin et al. 2002, Reay & Hinings 2005). This attempt has been denoted as the theory of institutional work, and this perspective is argued to overcome the shortcomings that previous perspectives within institutional theory have revealed (Lawrence & Suddaby 2006, Lawrence et al. 2009, Lawrence et al. 2011). Institutional work is aimed to explore the individual and collective actions, which consciously are undertaken in order to create, maintain and disrupt institutions (Lawrence & Suddaby 2006, Lawrence et al 2009, Lawrence et al. 2011, Lawrence et al 2013). Thus, the word “work” refers to work that is purposeful carried out by actors, and which goes beyond daily tasks in order to shape organizational life (Lawrence et al. 2013).

The creation, the maintenance and the disruption of institutions, are constituted of different types of work (Lawrence & Suddaby 2006). Since the aim of this study is to focus on what is expressed in the institutional work when a new strategic management model is implemented in practice, especially the *creation* of institutions can be regarded as important for the understanding of the dynamics of institutional work in the initial phase of an implementation process. Three types of work have been highlighted as crucial in the creation of institutions. These types of work participating are; theorizing, mimicry and construction of networks (Lawrence & Suddaby 2006, Monteiro & Nicolini 2014).

Firstly, theorizing relates to the work of producing chains of causes and effects between new practices and outcomes, in order to create legitimacy for new practices (Lawrence & Suddaby 2006, Monteiro & Nicolini 2014), which by Monteiro and Nicolini (2014) is argued to be a crucial factor in order to institutionalize new practices. They stress the importance of creating a feeling of that a new working approach functions as a solution to current issues (Monteiro & Nicolini 2014). Further, Lawrence and Suddaby (2006) stress, that the naming of new strategies and practices is a crucial part of theorizing, since the name of a new concept affects how it anchors into the cognitive map in an organization. For instance, Kitchener (2002), illustrated in his article that the naming of an organization, and its organizational characteristics, helped to create legitimacy for a new market-managerial strategy, within the American healthcare sector.

Secondly, mimicry involves the work of creating linkages and associations between old and new practice, to ease the adaptation to new institutions (Lawrence & Suddaby 2006, Monteiro & Nicolini 2014). Lawrence and Suddaby (2006), mean that it is possible to gain leverage in the work of creating institutions, if actors succeed in the linking between the old and the new. In the work of mimicry, it is argued that the design of a new strategy is of essential value. By designing a new strategy or technology, as so they create associations to old ones, it is more likely to accomplish a successful work of mimicry, and thus also succeed in the institutional work. For example, when Edison designed the light bulb, he created associations to the fire flame by the light bulb's design (Lawrence & Suddaby 2006).

Finally, the construction of networks is referring to the work of recruiting individuals and groups within the intra-organizational network, who can work as agents in the implementation process (Lawrence & Suddaby 2006, Monteiro & Nicolini 2014). Lawrence and Suddaby (2006), mean that previous loosely linked actors can construct networks to affect institutions and impact the creation of new institutions. Previous research highlight, that finding support for new innovations or new practices is crucial for a strategy to become successful (Monteiro & Nicolini 2014).

The Role of Materiality in Institutional Work

Since the introduction of institutional work, researchers have focused on studying the impact that humans have on institutional work. (Battilana et al. 2009, Coule & Patmore 2013, Lawrence et al. 2011, Monteiro & Nicolini 2014, Suddaby & Viale 2011). More specifically, researchers have been focusing on investigating; how institutional work emerges, who performs institutional work, and what establishes institutional work (Lawrence et al. 2013). Thus, human actors are argued to be able to change and create institutions (Lawrence and Suddaby 2006, Lawrence et al. 2013), and previous research highlights both institutional entrepreneurship and the role of professions, as important factors behind the creation and transformation of institutions (Battilana et al. 2009, Suddaby & Viale 2011). To exemplify, Suddaby and Viale (2011), stress in their article, that it is due to the professionals' unique position in the field, and their social skills that enables them to engage in institutional work, which is an evidence of human actors' capability to affect institutions.

However, lately, a demand for new directions within institutional work has occurred and the call for exploring the involvement of material objects has emerged (Jones & Massa 2013, Lawrence et al. 2013, Monteiro & Nicolini 2014). Researchers stress, that the dimension of materiality, has been largely overlooked in previous research, and argue that gaining understanding in the role of materiality in institutional work, can be of great value for future research (Monteiro & Nicolini 2014, Raviola & Norbäck 2013). In addition to Monteiro and Nicolini (2014), Pinch (2008) highlight that it is of great importance to include the material aspect, especially when studying institutional change.

Bringing materiality into institutional work, provide a new perspective to research within the institutional field, and researchers argue that materiality has an important role in the institutional work (Jones and Massa 2013, Lawrence & Suddaby 2006, Lawrence et al 2013, Monteiro & Nicolini 2014, Nicolini et al. 2012, Raviola & Norbäck 2013). Recently, researchers have put the role of materiality in center, and further stated that materiality

participates as an active part in institutional work (Monteiro & Nicolini 2014), It is argued that materiality functions as a trigger to institutional work, and thus contributes to questioning things that are taken-for-granted. Thereby, materiality opens up the black box of institutions (Raviola & Norbäck 2013).

Materiality constitutes for instance objects, artifacts, technology, spaces and time (Jones & Massa 2013, Monteiro & Nicolini 2014, Raviola & Norbäck 2013), and materiality is seen to be actively involved in the establishment of practices, and makes the practices durable over time (Nicolini et al 2012). Thereby, materiality is argued to provide an extension of human action, and contribute to the understanding of stabilizing social processes and organizations (Jones & Massa 2013, Monteiro & Nicolini 2014). Thus, materiality contributes to the construction of social life, which therefore cannot be explained without accounting for materiality (Latour 2005). It is stated that human action is dependent on materiality or even constituted by materials, and therefore materiality can be seen as scaffoldings, which enable and provide a structure of human action (Orlikowski 2006).

Monteiro and Nicolini (2014) argue that we need to include the role of materiality within the institutional maintenance, creation and disruption. They mean that materiality is as important in institutional work, as cement is for a mason. However, materiality does not have the same role in all contexts, but rather, they can play different roles, just like humans play different roles in different situations (Lindberg & Walter 2013, Monteiro & Nicolini 2014, Nicolini et al. 2012). Materiality can also be perceived differently by different people, and may therefore create tensions and conflicts among people and groups (Nicolini et al. 2012). Nicolini et al. (2012), argue that in order to create good cooperation around new practices, it is important to identify the differences in how materiality is perceived, and thus, prevent tensions and conflicts between human actors.

However, since materiality plays an important role in institutional work, it is also stressed to have a central role in the institutional work of theorizing, mimicry, and construction of networks (Lawrence & Suddaby 2006, Monteiro & Nicolini 2014). In Monteiro and Nicolini's (2014) article, a prize is studied in order to bring light on how a material object can create legitimacy to new practices, and thus create institutional work. Additionally, their article shows, how the work of theorizing, mimicry, and construction of networks is based upon materials. For instance, a pharmaceutical association, within the Italian healthcare sector, succeed to perform theorizing and mimicry by developing a website. The website was based on pre-existing information about the prize, which previously had been provided in a booklet. Additionally, the website also helped to stabilize and extend the life of the prize's message, and it helped to reach a wider audience. Further, materials also supported the construction of networks, and Monteiro and Nicolini (2014), show how advertising documents helped to create interest in the prize.

To conclude, institutional work refers to purposeful work, which is undertaken by actors in order to create, maintain and disrupt institutions. Our focus will lay in the work behind the creation of institutions, and more specifically in three types of work; theorizing, mimicry and construction of networks. By drawing upon the theories and elements discussed above, we will be able to explore the roles of both human actors and material objects in institutional work, in an initial phase of an implementation.

Research Methods

Research Design

In order to gain deeper understandings of a social phenomenon or a specific situation, it is beneficial to undertake a qualitative research method. A qualitative research method is usable in our study, since it offers a variety of research techniques preferable to use when studying how people and organizations are operating in practice (Silverman 2013). It is also argued that these techniques and methods are advantageous to use in healthcare research, since healthcare research often is connected to practical issues (Pope & Mays 2000). Thus, when studying implementation of new strategies, it is important to explore how people operate in their daily settings and how new working approaches are expressed practically, which such a method enables. This study is based on an abductive approach, where the empirical work has emerged in inference with the theoretical work (Czarniawska 2014, Mantere & Ketokivi 2013).

To collect relevant data to this study, we have conducted interviews, observations, and analyzed documents regarding the strategy of VBC. This has provided us with deeper understanding of the meaning of humans' and material objects' role in an initial phase of implementing a new strategy. The data collection was concentrated to five consecutive weeks, which can be divided into five different steps. These steps included different type of data collection techniques, but occurred simultaneously during the five weeks. In step one and two our observations were made. More specifically we divided the observations into; observations at The Clinic (step one), and observation outside The Clinic (step two). The interviews were conducted in step three and four. We separated the interview sessions into two parts, since they included different professionals. In total, we conducted data from approximately six hours of observation and fifteen hours of interviews. The last step, included a documentary analysis.

Data Collection

Our data has mainly been gathered through interviews, which has given us the opportunity to study how the new strategy of VBC is implemented in practice, and explore the dynamics of the institutional work at The Clinic. More specifically, fifteen semi-structured interviews have been held with different healthcare professionals, having different roles in the initial phase of the implementation process of VBC (see table 1). The interviews were loose structured and consisted of opened ended questions (Pope & Mays 2000), in order to create a flexible and interactive dialogue with the interviewees (Czarniawska 2014). During the interviews we used a list of pre-set questions, which were categorized into different core areas, and further used as an interview scheme, to ensure that all aspects intended to study were covered (Czarniawska 2014). Our interview scheme consisted of three core areas; (1) demographics (2) VBC and (3) previous working approach. These core areas were chosen in order to cover as broad information as possible about the current work at The Clinic, previous working approaches, and the perceptions of VBC.

All interviews were held physically in each interviewee's work environment with the intention to make them feel comfortable in the interview situation. Eleven of the interviews were held with individuals having daily contact with patients, while the remaining four

interviews were held with managers and project leaders working with the implementation of VBC. Each interview took between 45-60 minutes to accomplish. The length of the interviews was advantageous, since it enabled us to develop questions of greater interest, and create opportunities for the interviewee to describe its work more deeply, and relate to own examples and experiences. One of the main purposes with the interviews was to get access to the interviewees' narratives and own interpretations of their practical work. However, this is argued to be difficult, and to prevent these difficulties, we made sure that the interviewees got generous time to develop their answers (Czarniawska 2014).

Our contact person at The Clinic helped us to schedule individuals to interview. Three requirements were set when the selection of interviewees was made. First of all, the interviewee had to have worked at The Clinic for at least two years. This requirement was set to enable answers to questions in the third core area. Secondly, the interviewees had to represent different healthcare professional groups, in order to provide as broad understanding of the implementation process as possible. Finally, the interviewees were required to be represented by people not involved in the strategic work with VBC, and individuals who were strategically involved in the process (Czarniawska 2014). During all the fifteen interviews, notes were taken by one of the researchers, while the other one was focusing on the questions and to cover all important areas. In addition to this, the interviews were recorded and afterwards transcribed, to prevent biased results, and to not miss out on valuable information (Czarniawska 2014, Kvale 2008).

In order to obtain a more objective picture and broader understanding of the initial implementation process, four observations were conducted (see table 2). To keep an objective role, we conducted non-participant observations, meaning that we did not participate in any discussions or conversation during the meeting, but rather we observed others reactions, conversations and behaviors (Czarniawska 2014, Silverman 2010). The first observation was including an informative start-up meeting with two project leaders, responsible for the work with VBC. This meeting resulted in a broad introduction of The Clinic, and a presentation of general ideas behind VBC, and several internal and public documents related to VBC. At this meeting, the time-line and set up for interviews and observations were discussed. The second observation included a discourse of VBC, held by the hospital director, and this provided us with an understanding of the hospital management's view of VBC. The third observation was an workplace meeting, which is a monthly meeting where nurses and assistant nurses at the ward are gathered. At the workplace meeting, the project leaders of VBC hold an informative presentation about the cornerstones of VBC, in which time for questions from employees were given. This observation provided us with further understandings of how the management introduced the new strategy and work approaches to the healthcare professionals at the ward, and also how the employees perceived the new approach. The fourth observation was a meeting where the previous and future work of VBC was discussed. At this meeting both managers and professionals from the hospital were present and also the two project leaders responsible for VBC. Additionally, one representative from the hospital management and one external advisor were invited. This observation gave us insight in how VBC is discussed more strategically. We choose to take notes simultaneously as the observations were performed (Czarniawska 2014), in order to not miss out on interesting data. After each

observation, we compared our notes and thoughts in order to identify differences and similarities in our data.

In addition to the interviews and the observations, we gathered background information about the strategy of VBC, and information about the tools used at The Clinic. This information has mainly been conducted through documents, PowerPoint slides, and brochures (see table 3), which have been analysed, and which some also formed the basis for our interview questions. These documents have also contributed to further understanding of, and support to, the interviews and observations (Silverman 2010).

Interviewees' professions	# of interviews
Assistant Nurse	2
Nurse	4
Physicians	2
Physiotherapists	1
Project Leader, Value based care	2
Implementation Leader	1
Ward Manager	1
Medical and Ward Secretary	1
Occupational Therapist	1
Total # of interviews	15

Table 1: Interviewees' professions

Type of observation	# of observations
Start-up meeting	1
Discourse	1
Ward meeting	1
Work group meeting	1
Total # of observations	4

Table 2: The observations made

Documentary analysis	# of documents
Scorecard	1
Activity schedule for patients	1
Activity schedule for nurses	1
Information Brochure	1
PP presentation of VBC	1
Total # of documents	5

Table 3: The documents analyzed

Data Analysis

During our data analysis process, we used an abductive research approach where the theory and the empirical findings were developed and formed continuously during the research

process (Czarniawska 2014, Mantere & Ketokivi 2013). To analyze our collected data, grounded theory was preferable to use (Czarniawska 2014, Pope & Mays 1999), more specifically a constant comparative analysis of the gathered material was performed (Czarniawska 2014). After conducting the first interviews, observations, and documents, we started to analyze the material and searched for similarities and differences between them, and begun to code all data into categories (Czarniawska 2014, Pope & Mays 1999). For instance, some of the categories that arose in the beginning of the process were; materiality, perceptions of VBC, social networks, and old working approaches. Together these categories provided guidance for what was interesting to focus further analysis on. Through out the process, some themes became more relevant than others, and a re-categorization of some data was made. Further, connections between themes were searched for and identified (Czarniawska 2014), and finally three main themes, closely linked to the empirical data, were set as structure for the presentation of our empirical case; The introduction of VBC, Re-packaging VBC, and Outcomes of VBC.

Further, with our empirical data in mind, we constructed our analysis and discussion on the theoretical categories behind the creation of institutions, and more specifically, on three types of work, which are identified as present in our case, and which both Lawrence and Suddaby (2006) and Monteiro and Nicolini (2014) have highlighted as crucial types of work participating in the creation of institutions, these are; theorizing, mimicry and construction of networks. Since materiality, was early observed to have a crucial role in the work of VBC and since, a large part of VBC was noticed to have been materialized at The Clinic, theories regarding materiality were included in our theoretical frame.

The introduction of VBC

In 2013, the hospital management at our case hospital, intercepted Porter and Teisberg's (2006) ideas of VBC, and decided to undertake this strategy. Initially, the hospital management engaged a large American consultancy firm in order to create tools and a strategic plan for how to implement VBC at all hospital units until 2018. In the beginning of the implementation process four departments at the hospital were announced as pilot projects. One of them was The Clinic. At that time, The Clinic was struggling with long waiting times and a high percentage of dissatisfied patients in comparison to similar clinics in the country, and the hospital management was hoping that this new strategy was going to reverse the negative trend.

During the strategic development of VBC, the hospital management and the consultants established and constructed general tools, such as a scorecard, aiming to measure and control the results of VBC, in order to adapt the strategy into the Swedish healthcare. This scorecard was supposed to eventually be further adapted to each pilot clinic, in order to fit their specific patient groups. In the beginning, the consultancy firm was actively involved in the process, but eventually the consultants pulled back, and the pilot clinics were now supposed to implement the new ideas of VBC into practice themselves.

At The Clinic, a workgroup was formed and two project leaders were chosen to lead the work forward. In addition to these project leaders, the work group consisted of different managers from The Clinic. The work group had, together with a patient representative, the

responsibility to identify patient outcomes, which were creating value for their specific patient group. Through our interviews, it has appeared that one of the main preconditions for creating patient value at The Clinic, is to shorten the length of hospital stay, since being hospitalized increases the risk of infections, which in turn can lead to life-threatening complications. Previously, patients could be hospitalized for a week, but after introducing VBC, the patients are expected to leave The Clinic within two or three days after surgery. As soon as valid patient outcomes were identified at the Clinic, the practical implementation phase was initiated. To facilitate this implementation, the work group was reconstructed, and extended by healthcare professionals. Together the members of the new work group, developed additional tools and processes, which were aimed to facilitate the practical implementation of VBC, and further anchor VBC into the practical work at The Clinic.

This implies, that the strategy of VBC has traveled from the hospital management to the local context at The Clinic. By adapting the strategy, and by developing tools and processes, aiming to create value for their specific patient group, a repackaging of the general strategy has been made at The Clinic. We have identified several repackages of the strategy and four of them will be explained in next section. These four repackages are chosen in order to further understand the dynamics of institutional work in the initial phase of an strategic implementation in an already established organization.

Repackaging VBC

Our observations and our interviews identify that the repackaging of VBC has resulted in the creation of both material objects and social processes. By material objects we mean physical objects such as an IT-tool, documents and folders. Further, by social processes we mean processes and activities, based on humans' engagement and social relations. In this section, two of the material objects, the scorecard and the activity schedule, will be presented and explained, and thereafter two of the social processes, the process of mobilization and the meetings, will be declared.

Starting with the material objects, both the interviews and the observations in our study, show that an essential part of VBC has been materialized at The Clinic. An apparent example of this is the scorecard, which according to the project leaders, is one of the main tools and cornerstones in the practical work of VBC. The scorecard contains data regarding patient outcomes, process measurements, and financial measurements, which are registered in an IT-program, and it functions as the controlling tool of VBC. For instance, the scorecard contains data regarding patient's satisfaction of the surgery process, and the average waiting time for surgery. We have observed that the project leaders and management use the scorecard to allocate resources where it is needed, in order to create patient value. However, it appears from the interviews with the project leaders and the healthcare professionals, that the scorecard has been embraced differently at The Clinic. Until now, the scorecard has mainly been used by the project leaders and the work group to control and follow up the results of VBC. Thus, it is shown that several of the healthcare professionals are not very familiar with the scorecard, even though we have noticed in our observations and interviews that the scorecard has been exposed to the healthcare professionals during meetings and in emails. Our interviews indicate that there are different perceptions of the scorecard among

healthcare professionals. Some of them believe that the scorecard provides an encouraging effect, while others find the scorecard difficult to understand and to embrace in their practical work.

Further, the second material object is the activity schedule. The Clinic has recognized, that it is crucial to provide clear information to the patients, in order to decrease the length of hospitalization, and thus also increase patient value. Therefore, the information to patients has been materialized through this activity schedule. The activity schedule is a printed document, containing expectations of the patient, and information about exercises and activities that the patient are supposed to perform during the hospital stay, which before the introduction of VBC, was provided to the patient verbally. Thus, this information was used even prior to the introduction of VBC, but the activity schedule is a new tool, presenting these routines and activities in a more structured way, which enables the healthcare professionals to work more coherently and efficiently. Now, it is clearly shown in the activity schedule that the patients are expected to leave The Clinic within three days. Nurses and assistant nurses stress that the activity schedule has supported them in their daily work, since they believe that the activity schedule has created a greater awareness of expectations among patients, and also a willingness to follow the instructions. Thus, the activity schedule is another example of how ideas of VBC have been materialized at The Clinic.

Additionally, our study shows that social processes also have been developed in order to practically implement VBC. First of all, one of the social processes established at The Clinic, is the process regarding patients' mobilization. By mobilization the healthcare professionals mean the process of getting the patient to stand, to walk, and to regain its physical activity. The mobilization has even prior to VBC been important, but now the interviewees stress that they have a more structured way to mobilized the patients, and everyone are aware of its importance. Most of our interviewees, explain the importance of having a fast mobilization of the patient after surgery, since a fast mobilization results in an earlier discharge, which in turn decreases the risk for infections. Since the introduction of VBC, several of the healthcare professionals testify that they have become more pushy towards the patients. The mobilization process begins already ahead of the surgery, when the patient meet with different healthcare professionals, who inform about the importance of fast mobilization. Further, the physiotherapists help the patient to get up from bed immediately after the surgery, and thereafter the healthcare professionals push and support the patient to mobilize during the whole hospitalization. One of the nurses describes their work of the mobilization process:

“We have become more strict towards the patients, for instance by not serving them dinner in their beds anymore. Rather, we are anxious about that the patients shall leave the bed, and we try to push and support the patients as much as possible, in order to create a willingness among them to mobilize. I think we do a great job regarding this!”

Another social process, which has been developed during the work of VBC, refers to the dissemination of VBC. Currently, to disseminate the ideas of VBC, and to explain its tools and processes, the project leaders are using some of the existing workplace meetings. Our

observation shows that these meetings provide opportunities for all participants to discuss the meaning of VBC, and the project leaders are for instance given time to illustrate and explain the scorecard. We noticed, that the project leaders speak in an encouraging way, emphasizing the non-complexity of VBC, and stress that the healthcare professionals always have worked accordingly to the patient values included in VBC. One of the project leaders describes:

“At the workplace meetings, I describe what VBC is. I ask people about patient outcomes, and thereafter I let them describe their perceptions of patient value. Then I show the scorecard and say, you are absolutely right! That is exactly what we measure, it is exactly the same outcomes that we in this work group measure.”

Further, the interviews indicate that the ward manager continuously, at shorter morning meetings, confirm that the healthcare professionals are creating patient value, and also encourage them to continue to embrace the tools and processes included in VBC.

To summarize, four repackages of VBC, developed at The Clinic, have been described. Two of them are related to material objects and the other two refer to social processes. By this, we can see that both materials and humans have been involved in the work of VBC at The clinic. In the next section, the initial results of VBC will be described.

Outcomes of VBC

Our study has recognized several initial results at The Clinic, which can be presumed to be a result of VBC. Opinions are divided as to when VBC initially was presented for the healthcare professionals at The Clinic, but according to the healthcare professionals, changes have been perceived more obvious during the last six months. Firstly, the scorecard indicate that the production of patients has increased with 44 percent in comparison to last year, which also has resulted in a decrease in the average waiting time for surgery. Moreover, the healthcare professionals describe that they have noticed the increase in patient flow, since physicians are performing more surgeries, and nurses are coordinating a larger number of patients, and discharge them earlier now than previously.

Thus, as a result, the healthcare professionals are testifying of an increased workload. Although, they mean that their work has become more structured and efficient, after the introduction of VBC, it appears from our interviews, that some of them feel more stressed now than previously. Most of the healthcare professionals, perceive that VBC is not working when something in the care process is disrupted, for instance, when unexpected events occur. It is shown in our study that some of the healthcare professionals, especially nurses and physicians, argue that their workload becomes unsustainable in those situations. In contradiction to the healthcare professionals' perceptions about the workload, the ward manager mean that the stressful situations are not a result of VBC, but rather a consequence of that The Clinic still sometimes receives emergent patients, which should not be included in the patent group covered by the work of VBC.

Further, the interviews and observations indicate that the increased production of patients have called for an extended interaction between professional groups and different units, such as the theater, the x-ray unit, and the ward. The healthcare professionals perceive

that the cooperation has increased at The Clinic, and that the different professionals are working more unified now than previously. In addition, our observations have shown that more and more people are also getting involved in the work group.

Overall, the healthcare professionals explain that they believe in the strategy of VBC, and emphasize that patient value is the basis of their professions. Even though VBC is a new strategy, including new tools and social processes, several of the healthcare professionals stress that VBC is an obvious working approach to work in accordance to. However, there are some ambiguities, connected to the practical work of VBC, which have occurred.

First of all, our interviews indicate that the practical work of VBC has not been fully understood by the healthcare professionals. The interviewees can explain what VBC means for them, however, they cannot clearly describe how VBC work in practice. When healthcare professionals describe the work of VBC, some of them refer to several of the material objects and social processes included in VBC, while others refer to only one, or none of the material objects or social processes. Further, ambiguities have appeared regarding the meaning of patient value. Our observations indicate that some of the healthcare professionals perceive VBC as fuzzy, which also the project leaders admit that they did in the beginning of the implementation. One of the physicians states:

“Sorry, I was that bad at VBC. I have not been told that much about it. I usually think that VBC is a bit fuzzy. What is measured? How can we become more efficient? How can the care become cheaper, and how can it work better? I do not really understand. But it seems like it works.”

However, now The Clinic has tried to clarify the meaning of VBC, and one of the assistant nurses explain that they recently have put patient values into words, in order to create a more coherent view of value.

Secondly, because of the increased workload, some of the healthcare professionals question the quality of care. When their work situations becomes too stressful, they experience that the quality in care and patient value is challenged, and thereby several of the healthcare professionals emphasize the importance of a good working situation. The physicians describe that in pace with the implementation of VBC, they have less time for reflection and less time to meet with the patient and prepare for surgery, which they mean can both hamper patient value and obstruct their work situation. In addition, it appears in our study that nurses perceive that discharge within three days is highly in focus at The Clinic. However, they experience that this aim sometimes is challenging to achieve. When a patient wants to stay at the hospital and feels anxious about returning home, the nurses feel pressed and insufficient. In some occasions, the nurses admit that their assessments is that the patient might benefit from additional care.

Thirdly, as a result of The Clinic’s work with VBC, The Clinic has been praised with the hospital’s quality prize, and further they are nominated to a prize for the best development project within the Swedish public sector. The prize and the nomination have been posted on the staff room’s wall, in order to make it visible for the healthcare professionals. The project leaders have expressed in our study, that they hope the prize and the nomination will lead to an increased interest for the work of VBC among the healthcare professionals, and also that it

will create further legitimacy for the strategy. However, our interviews show, that this prize and nomination have not solely produced positive reactions at The Clinic. As an example, some of the units at The Clinic felt excluded from the prize, since they were not mentioned in the speech of thanks, even though they are involved in, and affected by the work of VBC. Further, some of the healthcare professionals express that they can not fully appreciate the prize because of the high workload, which sometimes make their work situation unsustainable. The prize and nomination is commented by a healthcare professional:

“It is tough! Of course, it is satisfying to win nominations and prizes, but to what price on us? We have increased the production significantly, however, in the end, we will not have the energy to cope with this increased workload. Therefore, I can not be fully satisfied by the prize. Because, what do we get? We have been told from the very beginning, that our work matters, and that the hospital management is bragging about the job we perform, but when you work this hard, those words do not mean that much to you.”

These initial outcomes of VBC show how VBC is expressed in practice, and the aspects presented above illustrate how the work of VBC has been received at The Clinic. This will further be analyzed and discussed, in order to explore how the dynamic of institutional work is expressed when a new strategy is implemented in an already established organization.

The unexpected role of materiality

In order to explore the role of humans and material objects in institutional work when implementing a new strategy, we will analyze and discuss these actors through three types of institutional work, namely theorizing, mimicry, and construction of networks.

Theorizing

Theorizing is the work of creating linkages between new practices and outcomes, in order to ease the adaptation to new institutions (Jones and Massa 2013, Lawrence & Suddaby 2006, Monteiro & Nicolini 2014). One important aspect in the work of theorizing is the naming of a new strategy or new practices (Lawrence & Suddaby 2006). It is shown in our case, that linkages between the strategy and the initial outcomes have been created at The Clinic, since healthcare professionals mention that some of the present outcomes, such as the increased production, are results connected to the introduction of new tools and social processes. Our study indicates that both humans and material objects are contributing to the work of creating these linkages, which is in line with previous research (Lawrence & Suddaby 2006, Lawrence et al. 2013, Monteiro & Nicolini 2014). An example of this interface, in the theorizing process, is when the nurses explain that both their new working approach, by being more pushy and supportive towards the patients, and the activity schedule, have contributed to the decrease in the length of hospital stay, thus created patient value. By this example, we have been able to identify that humans and material objects collaborate in the institutional work of theorizing, and that material objects extend human actions, which also is argued by previous research (Jones & Massa 2013, Monteiro & Nicolini 2014). This extension can be regarded as

a reinforcing effect, created by materials, of the institutional work. Another example of this reinforcing effect, is when the healthcare professionals say that they experience more structure in today's work. This structure seems to be established thanks to material objects included in VBC. Thus, it is noticed, that materiality can reinforce institutional work, by functioning as, what previous research call, a scaffold, which enables a structure of the healthcare professionals' work (Orlikowski, 2006).

With regards to the importance of naming, our study shows that the general strategy of VBC has been positively embraced into the local context, possible due to its close linkages to value. By naming a strategy "Value Based Care", the healthcare professionals may easily connect the strategy to the basics of their professions. However, some of the repackages, for instance the scorecard, have been more difficult for the healthcare professionals to comprehend. This may indicate, that the work of naming has not been that successful. For instance, would it been easier to embrace the scorecard, if it was named "the valuecard" instead?

Monteiro and Nicolini (2014) describe in their study, the positive role of materiality in the work of theorizing, which is closely linked to the reinforcing role noticed in our study. However, our study extends this research, by enlightening that material objects also can have hampering implications on the work of theorizing, an aspect which previously has been argued to be uninvestigated (Monteiro & Nicolini 2014). We have noticed in our study that material objects are inflexible in its design, which can cause negative implications of the implementation process, and hamper the institutional work. This inflexibility can for instance be illustrated by the activity schedule. This tool includes clear statements that the patient shall leave The Clinic within three days after surgery, regardless of the patient's conditions. However, this has created doubts in the practical work of VBC among healthcare professionals, who sometimes face an ethical dilemma when they have to discharge a patient that does not feel well enough to be discharged, or do not have the conditions to leave The Clinic in three days. However, the materiality does not have this ethical conscience, because of its inflexibility.

In turn, this negative and hampering role of materiality can result in arising tensions between humans and material objects. On the one hand, the activity schedule is a tool symbolizing VBC, and it states that it is of value for the patient to leave the hospital within three days. On the other hand, the nurses' professional assessment can be that it would be of value for the patient to stay more than three days. This shows that, sometimes the role of humans and the role of material objects pull in different directions regarding patient value, and thereby tensions may occur between them. In these situations, we can see that, as well as material objects extend human actions (Jones & Massa 2013, Monteiro & Nicolini 2014), there is a need for humans to also extend materials, since they can act as flexible actors in the individual assessment of patient value.

Mimicry

Mimicry involves the work of creating associations between old and new practices in order to facilitate the adaptation to new practices (Lawrence & Suddaby 2006, Lawrence et al. 2013, Monteiro & Nicolini 2014). Lawrence and Suddaby (2006), also highlight that the design of a new strategy has an essential role in the work of mimicry. It is shown in our case, that the

strategy of VBC is an appealing strategy for the healthcare professionals, since it is based on creating patient value. Already, in this general aim of VBC, we have noticed that the work of mimicry is present at The Clinic. It associates the new tools and social processes to the basic values within the healthcare professions. Our study shows that both humans and material objects are involved in the institutional work of mimicry, which also previous researchers have indicated (Lawrence & Suddaby 2006, Lawrence et al. 2013, Monteiro & Nicolini 2014).

Regarding humans' role in mimicry, the project leaders have been able to create associations between old and new working approaches, by constantly confirming the healthcare professionals' work, and highlighting that they already perform VBC. This seems to illustrate a successful work of mimicry, since our interviews, with healthcare professionals, indicate that they interpret VBC as an obvious working approach, and that they always have been working in order to create patient value. In other words, it is noticed that humans have a confirming role in facilitating the adaptation to new strategies.

However, material objects also contribute to creating associations between old and new working approaches. Our study shows that material objects has created an awareness and a clarification of the healthcare professionals' work, and further stimulated a discussion around how to work in accordance to VBC. This implies, that material objects have opened up the black box, regarding the work of creating patient value at The Clinic, which is in line with previous research, which also stress that materials triggers institutional work (Raviola & Norbäck 2013). Thus, also in the work of mimicry, materiality can be argued to have a reinforcing role. Another example of this reinforcing role in the work of mimicry is the activity schedule. The activity schedule seems to have been smoothly implemented to the practical work, since it is closely linked to old working routines. By creating a new tool based on old routines, The Clinic has been able to create associations between the old and the new, which have made the new tool accessible and easy to embrace.

On the other hand, according to this assumption, the scorecard would also have been easy to practically embrace at The Clinic, since it is based on pre-existing measurements, which were measured even before the introduction of VBC. However, our study shows that the scorecard has been difficult to embrace by some healthcare professionals, and further been perceived differently among our interviewees. This implies, that material objects may also have a negative role in the institutional work of mimicry. If material objects are vague in their linkages to old working approaches, they may become difficult to understand, and in turn, not be embraced into the practical work. By this, our study illustrates another aspect of materiality, which rather hampers institutional work and the implementation process than facilitates it, and further challenges the legitimacy of a new strategy. Again, this is an aspect, which previous research has left unexplored (Monteiro & Nicolini 2014).

Further, our study highlight tensions between humans and materials also in the work of mimicry. The roles of humans and material objects discussed above, describes the dynamics behind tensions that may occur between these two. In our case, humans emphasize that VBC shall be easy to embrace, due to its closely linkages to the basic values of healthcare professionals, and to previous working approaches. However, our study shows that some materials, for instance the scorecard, have not been able to create those associations among the healthcare professionals. Rather it has created confusions towards the strategy.

This illustrates, that humans and materials pull in different directions in some occasions in the mimicry work, and these tensions seems to have a hampering effect on the legitimation process of VBC.

When new materials are vaguely linked to old working approaches, they appear more difficult to embrace, and our study has identified that requests for getting these materials explained by humans, have occurred at The Clinic. This again implies, that humans and material objects benefit from cooperating in the institutional work (Lawrence et al. 2013, Jones and Massa 2013, Monteiro & Nicolini 2014, Raviola & Norbäck 2013), and that humans need to extend material objects in some situations in order to create successful institutional work.

Construction of Networks

The institutional work of constructing networks is referring to the work of recruiting individuals, who can work as human agents in the implementation process (Lawrence & Suddaby 2006, Monteiro & Nicolini 2014). In this initial phase of the implementation of VBC, we have seen that the construction of networks is made by both humans and material objects. Our study shows that the project leaders are trying to recruit enough people to the work of VBC, by talking about VBC in an encouraging way. Lately, several of the healthcare professionals have been recruited to the work group in order to be able to work as agents at The Clinic. Thus, our study highlights that humans have had an important role in the work of recruiting people and groups to engage in the work of VBC.

Material objects also seem to have a role in the work of constructing networks. However, this role seems to be more ambiguous. The role of materiality can for instance be illustrated through the quality prize, recently won by The Clinic, and through the scorecard. The project leaders use these material objects in order to visualize VBC. By making the prize visible, the project leaders hope to capture more healthcare professionals willing to engage in the work of VBC. This positive role of a prize, has previously been emphasized in recent research (Monteiro & Nicolini 2014), however our study contributes to this research by arguing that a prize seems to have a dual role in the institutional work of constructing networks. As well as a prize can reinforce the institutional work, it can also causes negative perceptions. These can have counteracting impacts on the recruitment work, and thus have a hampering effect on people's willingness to engage in VBC. These hampering effects on institutional work caused by materiality, have been identified in two situations in our case. Firstly, when the prize caused an excluding effect on some units at The Clinic, and secondly when it had a provocative effect on some of the healthcare professionals. Further, the project leaders have used the scorecard to visualize the strategy, and to create interest for the work of VBC, but our study indicates that the visualization of this tool has not only created awareness, but also caused confusion. Therefore the scorecard has not been able to create the interest that the management was hoping for. This confusion connected to the material objects may rather hamper the interest of VBC than contribute to the institutional work.

Previous research stresses that material objects can create tensions between humans (Nicolini et al. 2012), which also has been identified in our case. However, the study also indicates that tensions may arise between humans and material objects. We have seen that humans and materials pull in different directions because of the negative perceptions that

some material objects have brought about, for example the prize. Generally, a prize creates positive associations, and shall represent good performance. Thus, the prize at The Clinic is expected to symbolize the success of the initial work of VBC, and that The Clinic is working exceptionally in creating value and quality for their patients. However, healthcare professionals are questioning if The Clinic always achieves the expectations that the prize brings, especially when the workload is becoming too high and they experience that the quality is challenged. This further illustrates that the role of materials can cause tensions, which in turn have hampering effects on the work of constructing networks.

To summarize, we have explored in our study that humans and material objects are participating in the institutional work of theorizing, mimicry and construction of network. In contrast to previous research (Lawrence & Suddaby 2006, Lawrence et al. 2013, Monteiro & Nicolini 2014), our study have identified that material objects may have both reinforcing effects (figure 1), and hampering effects (Figure 2) on the different types of institutional work. Further, our study extend previous research by arguing that tensions between humans and materials may also occur and not only between humans (Nicolini et al. 2012) To overcome, or prevent such tensions it can be beneficial to extend the collaboration between humans and materials, and to account for these dynamics in institutional work.

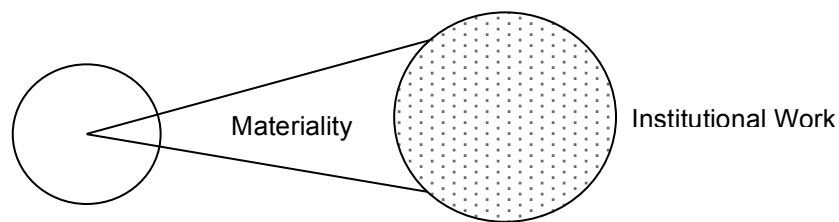


Figure 1: The reinforcing role of materiality

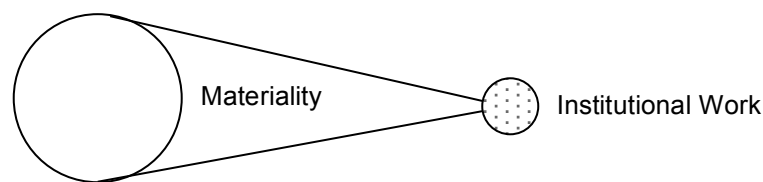


Figure 2: The hampering role of materiality

Concluding Remarks

The aim with this study was to provide further understandings of how the dynamics in institutional work are expressed in the initial phase of an implementation of a new strategic management model. By studying the initial implementation phase of VBC, at one of the major University hospitals in Sweden, we have been able to explore how The Clinic practically works with the strategic implementation, and identified how the ideas of VBC, has

been repackaged into several tools and social processes, in order to create legitimacy for the strategy. This study shows, how both humans and material objects take part in the institutional work at The Clinic, and that the dynamics in institutional work seems to have an impact on whether a strategy is being anchored in a local context or not.

In this paper we show, that material objects may have different roles in the institutional work. First of all, the study indicates that material objects contribute to reinforcing dynamics in the institutional work, and it was noticed, that the material objects extended humans' purposeful actions. However, we also have seen an unexpected, hampering role of materiality in institutional work, which have not been highlighted in research before (Lawrence et al. 2013, Jones and Massa 2013, Monteiro & Nicolini 2014, Raviola & Norbäck 2013). In some occasions, material objects did not have the positive effect as intended, but rather created negative or confusing associations towards the strategy. The negative aspects of materiality that was found in our study was connected to the materials'; inflexibility, its insufficient design, and its inability to create coherent perceptions. Further, we found in our case that, because of the hampering role of material objects, tensions arose between humans and materials at The Clinic, which also had hampering effects on the initial phase of the implementation. Our study proposes that these tensions between humans and materials, and the hampering effects of materials', could be overcome and prevented if the collaboration between these actors was extended, meaning that humans also need to extend materiality, in order to compensate for the three negative aspects of materiality mentioned above.

By this paper, we contribute to deeper theoretical knowledge within the research field of strategic implementation, and to the research of institutional work. The theoretical implications of our study are that both humans and material objects are important actors in institutional work, and further important to account for when implementing new strategic management models. Thus, gaining understandings of the dynamics of institutional work can benefit our understandings of how strategic implementation progress, and what determine its dissemination. It has previously been argued that new strategic management models are difficult to implement in healthcare organizations (Berlin & Kastberg 2011, Bååthe & Norbäck 2013, Hallin 2000, McNulty & Ferlie 2004). In regards to this, our study contributes with the knowledge that strategic management models, which do not achieve to create the reinforcing effects of materiality, are less likely to be anchored into local contexts. On the other hand, if materials are created to support and reinforce institutional work, it is more likely that a strategy becomes successfully anchored. Further, we extend previous research of institutional work, by showing that the hampering role of materiality can create tensions between humans and materials, and thereby cause further hampering effects on the institutional work, and on the legitimization of new strategies. Additionally, since our study indicates that there also is a need for humans' extension of materiality, we agree to, and further highlight, the importance of accounting for both materials and human actors in institutional work.

The practical implications of this article, is that people, working with strategic implementation in general, and the management at The Clinic in particular, can gain deeper knowledge in how to successfully use humans and material objects in order to gain support for a strategy, and thereby create legitimacy for its implementation. When implementing a new strategic management model, it is crucial to consider what material objects to use, and

which not to use. Especially, this is of importance in a highly complex organizational environment, such as the Swedish healthcare sector, where several professional groups and units exist, and where material objects can have different meaning and role among them. Some material objects may have a reinforcing effect on one group, but a hampering impact on another. Therefore, it is of great importance for management to reflect upon the different perceptions that can be created by different materials.

Regarding limitations, this study is mainly based upon data received from interviews, however the number of interviews are limited, and especially there are few interviewees from each healthcare professional group. A greater number of interviews had provided this study with deeper understanding of the nuances among different professional groups, and also contributed with further validity. Another limitation of our study is that, the interviewees talked to each other between our days of collecting interviews, which increased the interviewees' awareness of what we were about to study, and possibly affected their answers. Further, another limitation connected to our data collection is that, we were not involved in the final selection of interviewees, rather one of the healthcare professionals chose the interviewees for us, based upon our criteria, and thus, it is a possibly risk that her choice of interviewees affected our results. Lastly, due to the limited time of this research, our study had not the possibility to study the implementation over time, which had provided even a deeper understanding of the roles of humans and materials in institutional work.

Finally, our study makes suggestions for further research. Firstly, to connect to the study's limitations, it would be interesting to enlighten the role of material objects among different professional groups, especially since, our study has indicated that different perceptions between professions are existing. For example, by asking "How do different material objects affect different groups or professions in institutional work?" Secondly, since there are different scenarios taking place simultaneously at The Clinic, which has both reinforcing and hampering effects, it would be interesting to study this implementation over time, to investigate what eventually will happen to the strategy of VBC. Will it, like previous strategies, be abandoned, or will the institutional work at The Clinic lead to that the strategy becomes fully legitimated and maintained? Lastly, the aim of this study, was not to discuss or investigate the meaning of patient value, however, since our article shows that a large part of the work of VBC is based on material objects, it could be interesting to further investigate the implications of that a strategy based on value is being materialized.

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