SIGNIFICANCE OF CONTROL MODELS

- INTENTIONAL AND UNINTENTIONAL EFFECTS

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– Intentional and unintentional effects

Nursing and health care are popular topics of public debate. Reports appear daily in the media on shortcomings in the services on offer, staff having difficulties doing their jobs satisfactory, and problems with the financial result. This puts forward a picture of a sector that has considerable difficulties meeting the demands made by citizens and which is not sufficiently capable of staying within the financial framework set for it. Of course, it is possible to imagine problems from these comprehensive and sweeping criticisms of Swedish nursing and health care and alternative pictures may be drawn which show satisfied patients, high levels of skills and good control over the use of resources. It is possible to conclude that opinions on Swedish health care differs, and there is a great need for more facts.

The organisation of health care over the last few years has been subject to great change and attempted change as a consequence of new conditions and circumstances. Various kinds of work have already been done on structure, and different types of control models have been launched and implemented in order to enhance efficiency. It would appear that control experiments do not always – or even hardly ever – have the intended effects. The result is not in accordance with the ideas and expectations people had in respect of the new control model. Instead, problems in the operations are blamed for shortcomings in the control model applied, and the fact that the situation has got worse is often considered to be the fault of the last reform implemented. The conditions under which the models are introduced and reforms are implemented are often forgotten, and the new model is blamed for everything. For this reason, among others, there is a great need for research into the effects of control models on health care activities.

Research efforts

Organisation research has to a greater extent focused on reform work and changes, and many studies have been carried out which deal with the new reforms. These studies have often focused on the reasons for these reforms, rather than on the significance of the reforms per se (see for example Brunsson and Olsen, 1993 and Linder and Peters, 1996. Important conclusions drawn include the following: organisation experiments can legitimate the
operations, it is important to adopt to the last known reform, and it is important for ideas on new solutions to be disseminated such that organisations tend to resemble one another (see, for example, DiMaggio and Powell 1983, Czarniawska 1987, Jacobsson 1994, Brorström and Rombach, 2000 and Rövik, 2000). In organisation research the intentional explanations recorded, as results of carried out studies, are about implementing solutions that are appreciated by others, rather than trying to bring about enhanced efficiency and greater value for society.

According to conventional modern organisational research, organisation development is determined by factors other than formal rules and instructions. The informal institutions – routines, agreements, collective values – within the organisations make these organisations very resistant to change and difficult to influence with changes of routines (March and Olsen 1989, and Hodgson, 1999). Interpretation of changes observed complies with the results of modern organisational research and shows that these changes have come about as a consequence of external influences on the organisation and its staff. The significance of the institutions has not been altered due to internal rule changes. This interpretation is made at the same time as knowledge of the relationship between informal and formal rules and how change takes place is considered to be insufficient (see – for example – Boland 1991, Meyer and Scott 1992 and North 1993).

One question, which can be asked on the basis of the above reasoning, is why has such a wide-ranging assortment of reforms been launched and implemented over the last few decades, even though they are of such limited significance? One explanation provided on the basis of the perspective described is that the reforms were in fact never intended to actually influence, but to present a surface to the outside world showing that the organisation is willing to change and use the type of control model which is most popular at the moment. There are hardly any intentional incentives in the sense of the organisation wishing to bring about more efficient operations; everything is aimed at presenting fronts and rituals. The reason why this perception has grown so strongly is that researchers have chosen to read the data collected from this kind of perspective. They have actively sought explanations for changes other than those brought about by formal changes, and they have found them. As a consequence of this, the implicit hypothesis regarding the significance of the formal models has been rejected, and there has been a spread in the perception of the limited significance of the formal aspects.
Accounting research has according to Jönsson (1996) been concerned with understanding and explaining the role of accounting in practice. The focus is on how accounting information is used and how the information as such effects the individuals. One important study that clearly shows the effects of new kind of accounting information is Broadbent, Laughlin and Willig-Atherton (1994). According to the authors accounting information is used to legitimise a certain course of action; accounting is an ammunition machine. Another important study is analysing the implementation of a new administrative control system in a highly professional organisation (Abernethy and Stoelwinder 1995). The author’s conclude that not only will these control systems operate ineffectively, they are likely to have adverse individual and organisational effects. However there is a great need for further studies about concrete effects in the operations of different kinds of organisational reforms and management accounting models. This study is about a new control model based on a remuneration system, whereby the activities received payment for the actual work carried out. It is about a performance-based system.

**Point of departure**

A central starting point for the study carried out and this report is that formal aspects have their part to play; and one aim of the report is to describe the significance of formal change in the form of a new control model, and how the control model is used. With this as a point of departure, we then have criteria with which to develop our reasoning as to why formal control models are of significance. The approach which forms the basis of the study involves the view that what are known as informal institutions – routines agreements, collective values – are of significance, but also that they can be changed. The decisions and actions of individuals are affected by institutions, but decisions and actions are the means by which individuals can change the institutions. No institution can survive in the long term if it is perceived to involve erroneous action on the part of the individuals who follow it. Institutions change when they no longer benefit individuals. (For lines of reasoning developed in more detail, see Screpanti 1995 and Brorström and Siverbo 2001). There is interplay between structure and actor; to use the term coined by Giddens (Giddens 1984). One meaning of this approach is that formal changes of organisation and control system can be of great significance. Individuals develop
and change or challenge the existing institutional arrangement by launching and trying out new models and methods for management, control and organisation.

This report deals with a control model applied in maternity health care in Gothenburg, Sweden. The central model is based on remuneration for performance and the study focuses on the effects, which the control model and remuneration system implemented, have had on the midwives work. The model was put into practice for more than three years at the health care organisation studied. Perceptions of the model are described in detail and viewed against the control model requirements defined. This study was aimed at the local level, which means that the legitimacy of the model among the controlling elements and its influence from the point of view of the management have not been captured. The report concludes with a discussion of the significance of formal control models in a general sense and of why they are of significance.

In the study it is described how maternity health care staff perceive the remuneration model applied. Questions were asked relating to the experiences of midwives. Ten midwives were interviewed in the study: eight worked in prenatal maternity clinics in primary care in Gothenburg, and two worked in private units, one in Gothenburg and one in Stenungsund. The clinics were selected so as to attempt to capture and provide an overall view of the clinics in Gothenburg, with the similarities and differences that exist between different areas within the municipality.

The factors, which formed the basis for the selection, were geographical location, the social background of the patients, the size of the units and the economic results. Moreover, both clinics that took part in the trial prior to the introduction of the new control model and those, which worked with the new system only when it completely replaced the old one in 1997, were represented. Six people working in the care sector were interviewed in addition to the ten midwives. These people were selected due to the fact that they work in close cooperation with the maternity clinics in Gothenburg. The aim of introducing them to the study was to gain a broader perspective regarding the remuneration model and maternity health care by means of their supplementary statements. One idea was that the new remuneration system had not only affected the maternity clinics, but the surrounding areas as well.

**Description of the control model and remuneration system**
In 1997 in the maternity health care sector in Gothenburg, a new control model replaced the traditional overall budget and a new remuneration system whereby each maternity clinic received payment for the work carried out. The system was implemented in sixteen maternity clinics in primary care and one privately run clinic, Barnmorskegruppen AB. Politicians within the municipality initiated the new remuneration model and a group of officials were given the task of preparing a plan and a model describing how a system of this kind would be constructed. One starting point was that the model should promote and reinforce freedom of choice in maternity health care. Another intention was to “hive off” a number of maternity clinics – three or four of them – being run under the auspices of primary care, so that additional alternative units would be created within the system. The new remuneration model was to reduce overall costs for maternity health care by five to ten per cent. Barnmorskegruppen was to be included in the system and be given the same remuneration as primary care clinics, on the condition that they worked in a manner which tallied with the work of the other clinics.

In the decision data, it was established that a performance-based remuneration system assumes that both the quality and quantity of the work done is monitored constantly. This was why the remuneration model was introduced over two stages. The first stage was a test period in which Barnmorskegruppen and six maternity clinics in primary care tested the new remuneration system. This test period began in September 1994 and continued for a year. It was monitored constantly. This monitoring showed that there was a need for some changes of the model, partly in order to provide different levels of remuneration for first-time mothers and mothers who already had given birth, since mothers who already have given birth normally demand less resources.

The remuneration model was introduced at all maternity clinics in the second stage. At the time of introduction in 1997, the total budgeted cost amounted to more than SEK 31 million, excluding rent and capital service costs. The budget was divided into three areas of operation. Pregnancy monitoring took up three-quarters, contraceptive activities and health-work/area responsible/gynaecological health checks took up about half each of most of the remaining budget. There was also a minor buffer. All work carried out at the maternity clinics, except for the area responsible, was financed according to performance. All clinics apart from the private one were given area responsibility and varying levels of remuneration for this responsibility, depending on the social structure of the population in the respective areas. Achievements were divided into two basic programmes for pregnancy monitoring: one
for first-time mothers and one for mothers who already had given birth. The basic programmes included a certain number of visits from midwives and doctors. There were also supplementary remuneration types for five groups of complications/intervention, amniocentesis, interpreting, psychosocial complications, medical complications and infection screening. Contraceptive activities were divided into advice/check-ups, contraceptive pills, coils and pessaries. Remuneration was also given for performance in respect of gynaecological health checks. The structure of the model has been retained while this study was in progress but several of the remuneration amounts have been adjusted partly to compensate for rises in prices and salaries, and partly to improve the model.

The control model and performance-based remuneration

In this section we will describe the work carried out in the field of maternity health care. This description will also contain the views of the interviewees on this work and how the new remuneration model affects the ways in which this work is done. Work at maternity clinics consists of four elements: maternity health care, contraceptive advice, prevention of sexually transmitted diseases (STD’s), and gynaecological health checks. All clinics, which took part in the survey (apart from one), carry out these four tasks. One of the clinics chose not to offer gynaecological health checks. Even though the basic information is largely the same for all the clinics studied, there are variations in the service given. All the clinics offer training to first-time parents. This training takes place both in-groups and on a one-to-one basis. One-to-one training is common in areas in which large numbers of immigrants live. A number of clinics provide acupuncture if so required.

Maternity health care operations

Pregnancy monitoring and parental training: Maternity health care work can be divided into two areas: pregnancy monitoring and parental training. Pregnancy monitoring, which follows a basic local programme, involves both medical and psychosocial tasks. Parental training involves preparing parents for the continuation of pregnancy, childbirth and
parenthood both mental and practical preparation. According to a number of respondents, performance-based remuneration and the financial resources linked with the model have given less scope for parental training. The number of group meetings has fallen. In a number of clinics, particularly those with a lot of immigrants, group work has been toned down and training is carried out on a one-to-one basis to a greater extent. At one clinic, staff describes how they used to have natural family planning groups and special groups for single mothers and mothers who already have had children. These groups and this work have been discontinued as staff feels they no longer receive payment for these activities.

One respondent states that remuneration for first-time mothers is not sufficient; that it feels as though parental training is given free of charge. Another respondent states that the psychosocial element of maternity health care has worsened over the last few years, and that it is easier to make cuts there than in the medical part. If medical monitoring is tampered with, this is a violation, which is considered to be more serious. If the midwife is reported to Socialstyrelsen, the National Swedish Board of Health and Welfare, this may result in a formal warning being issued.

The Head of Public Health revised the local basic programme for pregnancy monitoring as late as the autumn of 1999. This revision included the removal from the programme of the planned visits from doctors to mothers who already had children. Instead, the individual midwives were given the task of assessing the need for these visits when the mother registered. The fact that the doctors’ visits were taken out of the basic programme is explained by the fact that there is a shortage of competent specialist gynaecologists and also by performance-based remuneration, which required cost reductions. The number of hours spent by doctors at maternity clinics has also fallen over the last few years, for the same reasons. A number of respondents are of the opinion that doctors’ hours have been cut back to a minimum. This development has led to individual midwives taking on more responsibility. It has also presented the clinics with new problems. One respondent said that one specialist wanted SEK 1000 an hour to work at the clinic. This was not considered reasonable, as remuneration for a normal pregnancy stands at just over SEK 3000. The same respondent said:

“You can’t put all your money into that doctor just to make sure the quality of the service is good. In that case, you have to use a doctor who might be less qualified but isn’t as expensive. We didn’t think in these terms before.”
There is a risk of complications for some pregnant women, and this means that they need additional attention from maternity health care. In the performance-based remuneration model, there are five kinds of supplement to the basic remuneration to the clinics. These supplements cover amniocentesis, interpreter costs, psychosocial complications, medical complications and infection screening.

According to Socialstyrelsen guidelines, all parents-to-be must be informed of foetal diagnostics. All pregnant women aged 35 or above must be offered amniocentesis. According to one respondent, the frequency of amniocentesis has increased, primarily in the central parts of the city, where a lot of people with high levels of education live who are well informed and plan their pregnancies carefully. In some suburbs, where a lot of immigrants live (among others), the frequency is lower, as there is less awareness and it is easier for difficulties with communication to occur between patients and staff. The number of amniocentesis tests carried out has increased by 12 per cent (from 388 to 434 a year) between 1997 and 1999, which may be due to higher numbers of pregnancies later in life and increased demand. The remuneration to the clinics currently stands at SEK 4224, which has to cover the costs charged by the hospital. For a time, the remuneration was lower than the actual costs, but the clinics were compensated retroactively.

As mentioned previously, the use of interpreters during pregnancy monitoring varies between maternity clinics. In total, payments to interpreters were made in 607 cases in 1999 compared with 526 cases in 1997, an increase of 15 per cent. According to one respondent, the present remuneration of SEK 2400 does not cover the cost for women who need an interpreter every time they visit the clinic. Interpreters cost the clinic SEK 375 an hour. The staff tries to restrict costs by encouraging relatives to interpret for the women, but this does not work for everyone.

According to the instructions issued by the Head of Public Health when performance-based remuneration was introduced, remuneration will be given for psychosocial complications if additional time required for visits by midwives, additional guidance and/or consulting with a psychologist, and joint action and planning with social services, the child welfare centre and the hospital are documented. If the midwife is of the opinion that the woman requires additional psychosocial support during her pregnancy, the midwife can hold such talks with the woman and receive additional remuneration for this on no more than two occasions throughout the pregnancy. The midwife also has the opportunity to encourage the woman to contact the psychologist who works part-time at the clinic. The number of
payments made for psychosocial complications has increased significantly during the period, from 1034 cases in 1997 to 1831 in 1999, an increase of 77 per cent. It is not possible to tell from the statistics available the extent to which this increase is due to additional visits to the midwife, additional guidance or extra co-operation/planning with other caregiver. However, the reports of respondents indicate that this increase is mainly due to additional visits to the midwife. There are also indications that the number of pregnant women who seek advice and support from psychologist after being encouraged to do so by their midwives has increased over the last few years.

Since the performance-based remuneration system was introduced, midwives have required a checklist of criteria regarding when additional remuneration will be paid. In early 1999, a list of psychosocial risk factors was produced as a basis for the assessment of the need for additional support. This list contained more than ten factors, including addiction, mental illness, relationship problems, acute fear of childbirth and particular social circumstances. However, a number of midwives are of the opinion that this list does not provide sufficient guidance, that there is too much scope for interpretation and this may mean that the amounts received by the different clinics vary.

Some pregnant women experience medical complications, or there is a risk that they will suffer from complications during their pregnancies. The clinics are given additional remuneration for patients with medical complications, but these complications have to involve at least two doctors’ visits, additional midwife checks or additional samples being taken. Here, too, a number of midwives say that they feel uncertain as to what is to be considered a medical complication and when additional remuneration should be paid. They are of the opinion that midwives in Gothenburg interpret and treat this differently, which affects the income of the clinics. When performance-based remuneration was introduced, a promise was made to issue a diagnosis list, which would provide the midwives with guidance in these situations, but no list of this kind has been prepared yet. According to the maternity health care consultant, it is sufficient for additional remuneration to be paid if the midwife suspects something that the clinic’s doctor should investigate, even if no diagnosis is made.

The specialist maternity care clinic at Sahlgrenska University Hospital says that the number of referrals has increased over the last few years. A doctor in the field of specialist maternity care described his view of the flood of referrals as follows:

“Many of the patients coming here now can just as easily… the staff at the maternity care centres have the skills and the opportunity to treat them there... As
soon as they fail to tally with the basic programme, they have a tendency to drop things in our laps, so to speak. And then we have trouble coping.”

According to this doctor, discussions are in progress between primary care and the hospital regarding the distribution of labour and costs in the field of maternity health care. Over the last few years, there has at the same time been a reduction in the time spent by doctors at the maternity clinics, and a number of clinics have had problems staffing doctors’ hours. Therefore, it is not possible to rule out the fact that the number of referrals to specialist maternity care has increased over this period. However, statistics, which indicate the development of referrals, have not been available. The number of additional payments made to the maternity clinics for medical complications has increased from 2213 cases in 1997 to 2692 in 1999, an increase of 22 per cent. However, from statistics available it is not clear how this increase is divided between additional doctors’ visits, midwife checks and samples being taken.

One question under discussion is whether the performance-based remuneration system has influenced the number of samples taken at the maternity clinics. One respondent is of the opinion that the taking of samples complies with the basic programme and that there is no scope for non-conformances. Discussions are under way at one maternity clinic relating to which samples should be taken there and which should be taken at the adjacent family general practitioner. Other respondents are of the opinion that clinics which have doctors who are not all that experienced, or where there is a high turnover of doctors, do a lot of tests “to be on the safe side” and carry out examinations which the maternity clinics do not have to do. Midwives say that they try to query these samples to keep costs down. One midwife tells about another situation of conflict:

“You could say that if we don’t take so many samples, the costs won’t be so high. But then again, it’s best to take samples. There’s a payment for complications. Of course, you can only use it twice, and it doesn’t cover everything. If I’ve got a patient who has to have certain tests to make sure she’s not got particular complications, the payment isn’t enough. But of course, I do the test anyway because the safety of the patient is at stake. In this way you could say that it (the remuneration) doesn’t affect us midwives in what we do – we look after the best interests of our patients.”

Furthermore, a number of midwives are of the opinion that it is difficult to keep check of the costs of samples as the laboratories’ reports come later, and then they are sent directly to the
financial office of primary care. The midwives are of the opinion that there are clear shortcomings in feedback on financial information to the clinics.

Women with an increased risk of infections which may affect their pregnancies undergo a special programme of tests, known as infection screening, including tests for rubella, HIV, syphilis and hepatitis, and chest X-rays. The main target group is immigrant women, and the maternity clinic receives additional remuneration for the tests done. The number of additional payments has increased from 1776 cases in 1997 to 2404 in 1999, an increase of 35 per cent. This significant increase indicates that the group of pregnant women screened for infection has grown. The documentation available does not indicate whether this increase can be traced to an increase in the number of pregnant women with an immigrant background, or whether it is due to indication slippage; that is, extension of the target group for infection screening. Few respondents comment on infection screening in their reports. However, one of the clinics pointed out that the additional remuneration for the tests does not cover the clinics’ costs, but has a negative effect on economic results.

**Contraceptive advice and STD prevention work:** The aim of contraceptive advice is to give people the chance to plan parenthood and thereby to reduce the number of abortions and restrict the spread of sexually transmitted diseases. The task of STD (Sexually Transmitted Disease) prevention work is to reduce the spread of sexually transmitted diseases. Thus both contraceptive advice and STD prevention work have the same aim, and in practice both these tasks are interlaced with one another in the work of the midwife.

The performance-based remuneration system includes four types of measure in the field of contraceptive advice: prescription of contraceptive pills, advice/check-ups, coil fitting and pessary testing.

The two former measures are the most common, while the latter two are less common. Between 1997 and 1999, the number of prescriptions for contraceptive pills at the maternity clinics in Gothenburg increased from 13537 to 15900 a year; in other words, by 17 per cent. Over the same period, advice/check-ups increased by 6 per cent, or from 13268 to 14032 a year. Coil fitting and pessary testing, on the other hand, have remained at the same level, around 1400 and 140 cases a year respectively.

Among the midwives of Gothenburg, there is widespread criticism of the remuneration for contraceptive advice and STD prevention work. A common argument is that these payments do not cover costs, and the fitting of coils is often cited in this respect. The
remuneration for coil fitting is SEK 300, and the coil itself costs SEK 170. One respondent said:

“The clinic itself has to pay for the coil fitted, and it costs more for the clinic to persuade patients to have a copper coil fitted instead of being prescribed contraceptive pills. You make more money on prescribing contraceptive pills or fitting a hormonal coil, because patients themselves have to pay for those. That costs SEK 1000 and stays in place for five years, so it’s quite cheap for each year it’s in place.”

Another respondent is of the opinion that the remuneration to the maternity clinics for contraception measures is lower than that given to doctors in private practice for the same work. When contraceptive advice is given, no payment is made for interpreters to the clinics, and a number of clinics have disputed this. They are of the opinion that they have trouble understanding the logic of remuneration for interpreters being payable during pregnancy monitoring but not for contraceptive advice. The clinics receive no specific remuneration for pregnancy testing: instead, this is regarded as being a part of pregnancy monitoring or area responsibility. The fact that these remunerations are perceived as low may provide the midwives with incentives to boost income to the clinic. One way seems to be to “redo” pregnancy tests when patients visit for contraceptives. One midwife said:

“If I do a pregnancy test which is negative, this isn’t such a big deal, but I take the patient into my office anyway. If she asks about contraceptive pills, I get paid for pills, but if we just sit and chat about the fact that she wants to get pregnant and I show her that you can get pregnant here and count like this, should I get paid, or should I just add her to the statistics? I charge for everything and document everything.”

Coils are normally fitted on request during postnatal check-ups. One midwife says that if you give the patient a check-up before the 12th week, this is included under pregnancy monitoring. Then the patient is told to come back four weeks later to have her coil fitted, and the clinic gets paid for the coil. There are also examples of clinics which report an additional visit for new mothers as contraceptive advice. Another example is of the midwife who sits with a patient in the contraceptive clinic for an hour and a half. According to the midwife, you then have to find a way of getting more money, and sometimes the patient will then be double-coded; that is to say, documented as two contraceptive visits.
Another part of the work, which causes worry for the midwives, is testing with a view to prevent STDs. The clinics have previously received no remuneration for these tests. Some midwives are of the opinion that it is a matter of weighing up the pros and cons of each case, and the demands and medical needs of the patient are set against the clinic’s costs. The maternity health care consultant verifies that testing has been low at the maternity clinics. However, as of the autumn of 1999, the clinics will be paid for their testing costs in connection with STD screening. However, to date the testing frequency has not increased to any great extent at the clinics. One explanation for this may be that not all midwives are aware of the change in conditions.

**Gynaecological health checks:** Cell sampling for the prevention of cervical cancer – or gynaecological health checks, as this is normally known – is the fourth main task of the midwives. The gynaecological health checks were previously carried out by six units in Gothenburg, of which two or three were gynaecological outpatients’ clinics and three or four were maternity care centres. When open specialist care was shut down in Gothenburg, these outpatients’ clinics disappeared, and the checks were transferred in their entirety to the maternity care centres. This transfer took place at the same time as a reduction in the birth rate in Gothenburg, and therefore maternity care centres had the opportunity to deal with these checks. The maternity health care consultant describes the fact that the midwives deal with these checks very well. They are praised very highly by the laboratory responsible at Sahlgrenska University Hospital, which states that the samples they take are technically very good. The target group is women aged between 30 and 50, who are called for tests every four years. In Gothenburg, the number of checks reported by the maternity clinics has fluctuated between 7000 and 7800 a year between 1997 and 1999.

These checks cannot actually be called health checks as they are carried out quickly one after the other, with two or three patients for each quarter of an hour, according to a number of respondents. During this time, there is not much scope for questions or discussion between the patient and the midwife. One clinic queried whether these checks are worthy of the name of health care for women. The remuneration to the clinics is SEK 75–80 per check, when costs for analysis and notices to attend have been deducted. This low remuneration makes it necessary to carry out checks according to the conveyor belt principle, according to a number of midwives. Nevertheless, they are of the opinion that it is difficult to cover the costs of this service. This quotation illustrates the problem:
“We saw a woman last Friday who wanted a well woman check and contraceptive pills. She spent an hour with us before, and she must’ve taken an hour and a half last Friday. We get SEK 150 for this kind of patient, who we’d normally see in 20 minutes. We don’t want this kind of patient. We did the job out of consideration for her, but there’s no scope for it.”

Many of the women given notice to attend cancel late or do not turn up, which means gaps in the clinic schedules. It is also common for a lot of people to call and ask to change their appointments, and this creates more work. One of the midwives calls the checks pure loss-makers. Another example of the financial problems is that one clinic which took part in these checks to start with refused to continue later on (about a year later) due to a poor influx of patients.

**Operation promotion activities:** One recurring theme in what the midwives have to say on further training is that less time is spent on further training than prior to the introduction of the performance-based remuneration. Now midwives are being more careful about what they prioritise as regards the further training in which they take part. Previously, it was common to close the clinic and for all staff to take part in the further training. Nowadays, at least one person stays at the clinic, and often now only one member of staff takes part in the further training day and then reports back to the others. The main reasons for this change are the demands for income and higher prioritisation of availability for patients. One respondent says that participation in further training fell considerably once the performance-based remuneration system was introduced, but that it has increased again over the last year.

The further training also provides opportunities for experience exchange and comparisons between colleagues. Midwives from Gothenburg describe their working conditions compared with those of their colleagues in Mölndal and are of the opinion, for example, that the midwives there can give women the option of two visits after the birth. In Gothenburg, remuneration is paid for only one visit. The overall budget model which the Mölndal staff has involves – according to some respondents – less administration than the performance-based remuneration system, and this means that the staff in Mölndal have more time to devote to their patients. A number of respondents say that most of their colleagues in Mölndal are always present at further training courses.

Another element of maternity health care is **operation development**, which covers both doing present tasks more efficiently and regenerating and adapting the work to suit different
conditions. A number of midwives have ideas on how work at the maternity clinic could be developed. One midwife says:

“Loads of people come here who I think we should deal with – people with menopause problems. And the midwives really could deal with them, now that there’s a shortage of GPs. The midwife could provide information before the patient goes to see her GP and gets medicines she might not take. But we can’t deal with these people at present, because we don’t get paid for them.”

Another new idea mentioned is incontinence treatment. Other midwives want parental training to be extended and further developed. Still another idea put forward involves the development of the gynaecological health checks into all-out health checks with discussions and a review of patients’ health profiles. But there are no financial opportunities to implement these ideas in reality at the moment. A number of midwives are of the opinion that the performance-based remuneration system means that they cannot take part in new joint action projects. They often meet little understanding from their partners in social services, the child welfare centre and the rest of primary care, who all work with overall budgets. One respondent is of the opinion that the remuneration system engenders a fear of embarking upon new development projects: people always have to ask themselves how these things are going to be financed.

Other respondents point out that it has become considerably more difficult to get the midwives to take part in various research projects. There is no longer the same interest and commitment to quality studies. One midwife says that gynaecologists at SU often want them to collect research material for various studies, but that the clinic has to set limits, and ask who will pay. They receive no remuneration for this in the performance-based model.

An important part of the work of the midwife is joint action with other caregivers to create a coherent care chain for the pregnant woman and her baby. Here, performance-based remuneration seems to have placed the midwives in more difficult situations as regards prioritisation. A number of midwives are of the opinion that there is insufficient time for joint action meetings with schools, social services, care centres, etc. in their own areas. They have to give priority to being in the clinic and working with patients. Other midwives say that they see joint action as important and they try to give it priority. One recurring view in the reports is that the amount of time available for joint action has fallen over the last few years. Representatives of the child welfare centre and social services confirm this development. One
child care centre reports that former joint action meetings have been replaced almost entirely by written messages and telephone calls.

The descriptions of the midwives also show that the amount of work done by the clinics in the outside world has dropped over the last few years. Of the midwives interviewed, few say that they take part in sex and co-existence lessons at schools. There also seem to be fewer schools/classes visiting the maternity clinics for information purposes. Several people also feel that the area responsibility is unclear, that it is poorly defined in respect of what is and is not included in it. There is a tendency for this remuneration to be viewed more as a general financial residual item and not as a grant for specific tasks.

Another question discussed with the respondents is whether the performance-based remuneration system has influenced the joint action/competition between the maternity clinics. Most people are not of the opinion that the remuneration system has made any difference in this respect compared with before. However, some people point out that the demands for income have meant that staff has to look after their patients more. Some mention availability as an important factor. One clinic reports that many patients from an adjacent area have started to go to them as they heard from the other clinic, that “you’re taking our patients”. Previously, many midwives stayed more strictly within their areas and their “patches”, but things are more flexible now. Another sign that the competition between the clinics has been stepped up is that some clinics, which had a surplus of income over expenditure in their annual accounts, have been subject to the questions and criticism of others. Examples of questions they have been asked include “how come you have so much money left over? Have you not filled the forms in correctly?”

As far as competition is concerned, it is interesting to look at whether the clinics’ marketing has changed. Most people are of the opinion that there have been no changes. One of the features in this respect is that there are rules, which limit marketing. The best idea seems to be to offer good care, and this “spreads like rings on the water”. The patients are the best messengers. One respondent declares that they have to make themselves available a lot. As a midwife, one has to actively answer the telephone and take care about having the answering machine on. Some clinics also do well out of their central locations.

Each midwife does her own monthly accounts in which she states what she has done in the form of the number of visits and income for the clinic. Most respondents replied that the remuneration system has not affected co-operation within their own clinics, but a number of them provide examples, which reflect problems in this respect. One midwife is of the opinion
that they think twice before leaving work to go home. Some say that the remuneration system has created problems in other clinics. One respondent describes a conflict of this kind, which was partly due to staff members having different performance levels.

One clinic reported that a midwife said that she had not earned much one month and kept on about it all the time. The other midwives said that we all worked together, and if we were to end up with a deficit, we’d do it together. The demand for income means that a lot of people feel pressurised, but there is nothing to be gained by setting people against one another, in the opinion of one midwife. Another respondent is of the opinion that the remuneration system makes requirement’s of the staff, but believes that rather, it has forced higher levels of co-operation within the clinic in order to get the books to balance. The reports of the respondents also provide examples of another type of link. One clinic reports that the midwife who gets the highest salary is the one who does the most work and is generally talented.

**The advantages and disadvantages of the remuneration model**

As can be seen from the report above, the respondents have plenty of views on the performance-based remuneration model and its effects on work. This seems to have become a central topic of conversation at a number of maternity clinics, and it has led to many animated discussions at unit meetings and further training days in maternity health care. One attempt to summarise the views of respondents is made up by their descriptions of the advantages and disadvantages of the remuneration model.

One advantage of the model, which is described repeatedly in the statements of the respondents, is the fact that it has enhanced staff awareness of costs. Staff has become more aware of what things cost; personnel, tests, and so on. Another view, which recurs, is the fact that it is more apparent what staff is doing; the statistics show that the clinics have a large influx of patients. The model has helped to illustrate the work. One respondent emphasises that it is an advantage if the money follows the patients, so the money follows them if they come in from another area. This has improved things for the patients, reckons another respondent. Staff is more service-minded because patients “have the cash in their handbags”.

One respondent tells that more flexible staffing is another advantage. When the number of patients increases, we can increase the number of hours midwives work. We are able to
cover costs in such situations with this system. “Before you could yell until you were blue in
the face but you’d not get any more staff working.” Another type of advantage, reckon some
people, is that the system gives the maternity clinics more independence in the primary care
area. The money in the remuneration system is earmarked for maternity health care, and the
primary care centre cannot reallocate it to its own operations. The primary care at area level
exert more control over the operations, which are financed by grants.

According to the respondents, the remuneration model and its application also have a
number of disadvantages. One thing, which a lot of respondents emphasise, is the lack of
clarity as regards what results in remuneration and what does not. The contents of medical
and psychosocial complications are just two examples of this lack of clarity, which leads to
varying interpretations by different midwives and clinics. The interpretations made affect
the income of the clinic. A number of midwives would like to see clearer guidance in the form of
a manual or similar which would reduce the scope for arbitrary interpretations. In addition to
this, the remuneration system has to be adjusted continuously so that the clinics are able to
cover the costs of what they do. It is not enough to redistribute funds between various areas: if
costs increase, primary care has to be prepared to contribute funds. Furthermore, there must
be someone in primary care that is responsible for the system and its development.

Another disadvantage stated by many is the fact that the remuneration system has meant
more administration: there are more forms to fill in. Staff has to constantly remember to fill in
reports in order to get the correct remuneration. Discussions at the clinics on the correct
remuneration have taken a lot of time and energy, at least to begin with. Administrative tasks
are considered by some to be a disruption to work with patients.

Other disadvantages of the remuneration system described include the work becoming
more hectic; staff is stressed more by requirements made in terms of performance and income.
Staff feel they are alone with the remuneration system: their colleagues in Mölndal with an
overall budget are deemed to have better conditions and are able to devote more time to their
patients. This difference is frustrating, according to a number of midwives interviewed. One
disadvantage, according to one respondent, is that the system has meant that staff gives
priority to work with patients over further training and other joint action which enhances
quality. A number of respondents also describe the system as rigid: payments are received for
certain things only. It is extremely difficult to develop operations and add any extras. It is not
possible to add contents to the system on which midwives want to concentrate. One
respondent, unlike most others, wants to simplify the system by doing away with the current
supplements and collect the remuneration in a “maternity fund” for each pregnant woman. The reason for this is that it could reduce administration.

A number of respondents also state that the remuneration system has no financial incentives: it does not seem to matter whether clinics are running at a profit or a loss. Midwives from two clinics had this to say:

“We thought we’d be able to keep our surplus until next year, in case we needed it. But we were swindled a bit. First of all, they said that if we had any money left over, we could fix up the clinic, do some training. And we believed them. We worked like slaves the first year and ended up with a surplus, but that was sucked in by the care centre. So we said never again. Why should we do that?”

“We have the same boss as another maternity care centre. They ended up with a deficit, we had a surplus. The boss’ comment was that it was great that the two amounts cancelled one another out. You used to feel motivated to make ends meet, but now you can feel the motivation is on its way out. You think, but of course we should do that course.”

One respondent considers the lack of incentive as a sign that the remuneration model is not working, that it has been implemented at the wrong time. It is an alien element in primary care operations in which there is a tradition of grants and overall budgets.

If respondents were permitted to choose any remuneration model they liked for maternity health care, there were two main concepts. One group is of the opinion that the remuneration system is a good foundation, but that it has to be further developed, become clearer and cover costs in full for the work done. It must also be possible to include new activities in the model. Another group declares that overall budgeting is preferable, remuneration for performance is perhaps suitable for industry where products are manufactured but it is not suitable for health care: people’s health is at stake. People are of the opinion that so much is done in this area that it is difficult to price and slot into the model. One view is that it is easier to get more out of staff in an overall budget system as staff avoid disruptive administrative tasks and are able to focus wholeheartedly on their work with patients.

**Adaptation and adjustment**
The control model applied in maternity health care has created new financial conditions for operations. In this section, we will describe the effects the model has had under the headings of Adaptation and Adjustment.

**Effects of the model – adaptation**

Adaptation is about the midwives’ changing their behaviour as a consequence of the performance-based remuneration model. Adaptation is perceived to have taken place in three different ways. One way is to not carry out any activities for which the system provides no remuneration. Work done in high schools is one example of activities that no longer take place in a number of clinics. Natural family planning groups and parental training groups for fathers and single parents are other examples of discontinued activities. There are also examples of clinics that have stopped providing acupuncture for the same reasons. One clinic has also stopped offering gynaecological health checks due to the fact that its costs are not covered.

Another way is to tone down and reduce activities, which do not provide direct income for the clinics. Parental training is one example of this, with fewer meetings and more one-to-one training and advice. Joint action with social services, the child welfare centre and other primary care is another example. There are indications of less participation in joint projects, fewer joint action meetings and more telephone calls instead in an attempt to save time. The reduction in the number of hours spent by doctors at the clinics is due to financial restrictions and the shortage of gynaecologists. However, the clinics’ additional costs for what are known as “doctor relays” have been covered since 1999 by a central grant within primary care.

A third way is to aim more towards activities, which generate income for the clinics. Patient work at the clinics seems generally to have been given priority over activities such as further training, joint action and business development. The time between pregnant women’s visits to the clinics has been filled up more accurately with contraceptive patients, in particular, in order to generate income. Furthermore, parts of the administrative work have been given priority, particularly work with the monthly reports, despite the fact that many midwives do not like it, as this report is necessary if the clinics are to receive their income.

However, adaptation also has to do with change on another level; adaptation of one’s own thought patterns. From the respondents’ reports, it is clear that the performance-based remuneration model has also affected midwives’ ways of thinking of their patients and their
work. Financial considerations have become more prominent: work is viewed more in respect of expenses and income. The midwives have gained a different way of thinking to other people in primary care who work with an overall budget. Finance is constantly at the back of their minds. It has become obvious that time are money and that the patients are the ones carrying that money. As far as the staff are concerned, it has become obvious that what they do is of significance to the finances of the clinic.

Here, there is an essential difference between the midwives in the primary care clinics and the midwives’ clinic in Gothenburg, which is run privately. At the latter clinic, staff has worked with performance-based remuneration since the start, and so they have not had the same dramatic switchover as their colleagues in primary care in this respect. As far as the maternity clinics in primary care are concerned, the introduction of the new control model has meant great emphasis on economy in what they do and clearer financial thinking among staff. In health care, medical considerations and care considerations dominant and these prioritise individual patients. A shift to a more financial focus in health care can mean that traditional standards are challenged and that staff is faced with ethical dilemmas.

Thus one effect of the new control model seems to be both an adaptation of the work done and an effect on the ways in which staff think and act. The rules are adapted in the new control model with the aim of creating financial balance in the operations. This adaptation is supported by changes in ways in which staff thinks and act.

**Effects of the model – adjustment**

The application of the control model has also carried along an adjustment of the model. This means that the midwives adjust and supplement the model so that it better suits their notions of what they do and how they do it. The respondents’ reports contain a number of examples of this kind of adjustment. An extra visit after childbirth is accounted for as a contraceptive visit. Coils are not fitted during postnatal check-ups, but later on at special visits. Pregnancy tests are regularly combined with contraceptive advice or the prescription of contraceptive pills. Patients who spend a long time getting contraceptive advice are double-coded. Acupuncture treatment is recorded as a medical complication. The number of additional payments made for psychosocial complications has increased from 1034 cases in 1997 to 1831 in 1999, an increase of 77 per cent. Some of this massive increase can probably be explained by
adjustment. There are descriptions in the respondents’ statements that support this interpretation. Another example is the incontinence advice activity, which is run on a small scale within a clinic: the patients are recorded as a contraceptive advice visit.

Adjustment takes place partly contrary to the formal rules of the control model and partly in grey areas in which there is scope for various interpretations to be made. The midwives want to be paid for the work they do, and when the control model makes no provision for remuneration, at least some midwives consider it reasonable to adjust the model so that the clinic receives remuneration. This adjustment can be viewed as an expression of the fact that medical and care standards are given priority over the rules in the financial control model. One midwife says that her clinic has changed its strategy. They go on training days, they allow patients to return as many times as they need to, and they have stopped caring about whether they are running at a financial deficit.

The ways in which the clinics’ financial surpluses or deficits are dealt with have further complicated the application of the control model. As has been mentioned earlier in the respondents’ reports, at least some midwives’ clinics reckon that it is not worth working towards a financial surplus as this is swallowed up by the other operations in primary care. Others are also of the opinion that it does not matter whether the accounts are in the red: there will be no consequences for the clinic. The number of staff will not be reduced, and no new cost-cutting measures will be imposed on the clinic in general. These perceptions of the handling of surpluses and deficits reinforce the development expressed by the adjustment. There seems to be declining respect for the control model among the midwives.

Staff reactions to and ways of dealing with the control model and the remuneration system can be summarised partly in gradual adaptation to the model and partly in a gradual adjustment of it. These are two processes in progress simultaneously at the clinics. The first may be perceived as acceptance of the model, while the other may be viewed as criticism of it. The adjustment is an expression of the fact that the control model should be adapted to a greater extent to suit what the clinics do.

Some final comments
This study paints a picture of the significance of control models and remuneration systems. Criticism has been levelled against the model, and in some areas there is a lack of knowledge of the control model and the remuneration system, but the model does obviously have great actual significance in various ways. Staff has adapted to the model and the conditions resulting from it, and the criticism of the control model also arises as a consequence of this adaptation. The model has also been adjusted to suit reality and the work for which it is intended. This change has meant intentional effects in the sense that the work has been adapted to suit the conditions given, but also unintentional effects in the form of attempts to outwit the system. Whether the attempts for adjustment, and the transaction costs or dysfunction’s (see Birnberg 1992) signified by this adjustment, are acceptable is a matter partly for system managers, and partly for continued assessment. This observation, which we find interesting by way of a conclusion, is that the formal element is of significance; and the interesting question is, just why is the formal element of significance? In earlier studies in the research group, it has been maintained that the formal element is of significance, but that this presupposes that the formal changes are in keeping with the values, which prevail within the organisation (see Brorström and Solli 2000). This is probably an explanation even in this case; that there is a certain developed acceptance for the type of control model implemented.

A study of the prevailing organisational ideal at present indicates significant confusion as to what this ideal actually is. Another prominent feature is that there is currently a very broad range of different solutions. The wave of market-like solutions, which washed over the public sector in the early 1990s, still has a certain role to play. The concept is not as strong any more, but as there are a range of applications in practice and – of course – a number of advocates (even though there are fewer of these than before), the concept is of significance. These market-like solutions are mixed in with concepts on joint action, co-operation and co-ordination; structures which are based on completely the opposite logic, that it is not competition but co-operation that causes efficiency and development. Hence a complete concept confrontation. Another characteristic feature of the current situation is that confidence in major administrative reforms is fairly weak. It is more about making changes to the work done, rather than about implementing administrative reforms and restructuring. The current situation can be characterised by “everything goes”, and most things are taken seriously within this framework. When the ideal is taken apart and becomes more muddled, there is more scope for actual application and less risk of isolating concept from reality. The
defence against administrative solutions has slackened off, and organisations have become much more amenable to actual change.
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