


## RESEARCH ARTICLE

# Exploring healthcare authorities' decisions to sustain or abandon a management control initiative

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## Abstract

We explore how a management control initiative travels across and is translated within organizations—from the decision motives for adoption or rejection to the subsequent decision motives for sustaining or abandoning the control—through the lens of diffusion theory. Our empirical case is the journey of activity-based funding of hospitals across 21 Swedish healthcare authorities. We develop a framework in which the abandonment or sustainment of a management control is explained by the interplay between the decision motive underlying the adoption and the propensity to continuously adapt it in response to new organizational goals and circumstances. This propensity is determined by fits and misfits between organizational characteristics and properties of the control.

## KEYWORDS

abandonment of management controls, activity-based funding, continuous adaptation, decision motives, sustainment of management controls

## 1 | INTRODUCTION

The diffusion of management control initiatives has been studied for long in both private and public sector organizations (PSOs; Ansari et al., 2010). Research on PSOs (Carvalho et al., 2012; George et al., 2019; Kantola & Jarvinen,

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2012; Laegreid et al., 2007; Lapsley & Wright, 2004; Lehtonen, 2007; Mattö & Sippola, 2016) as well as private firms (Ax & Bjørnenak, 2005; Bjørnenak & Olson, 1999; Kennedy & Fiss, 2009; Malmi, 1999; Malmi & Ikäheimo, 2003; Modell, 2009) suggests that the adoption of management controls depend on contextual factors, that early and late adopters have different decision motives, and that controls should be regarded as dynamic, subject to adaptations by each adopting organization.

This article examines two aspects of the diffusion of practices that are largely unaddressed by the extant literature. First, empirically, even highly influential controls are not universally adopted. To build an understanding of why some organizations decide to reject novel and influential control initiatives, it is insufficient to study organizations that adopted the control. Second, the emergence of a novel control is just one of many possible reasons why an organization may decide to abandon a control. Further insights on why organizations decide to sustain or abandon current controls may be gained from studying settings in which the alternative option would be to return to the previous controls.

We draw on a number of cases from the Swedish institutional setting to explore PSOs' decisions to adopt or reject an influential control initiative and, in turn, to sustain the control or abandon it for the previous one. Specifically, we contrast two dominant hospital funding models: activity-based funding (ABF) with prospectively set prices that vary across patients grouped in so-called diagnosis-related groups (DRGs) versus traditional budgeting based on historical costs.

The two funding models embody different properties in terms of normative claims, political loadings, and technical features. DRG-based ABF was pioneered by the US Medicare in the early 1980s, and similar models have since been developed in most developed countries (Busse et al., 2011; Palmer et al., 2014). ABF can be seen as a leading example of a new public management (NPM)-inspired control, which has complemented or replaced traditional public administration (PA) controls based on rationales to improve efficiency, effectiveness, and accountability (Funck & Karlsson, 2020; Hood, 1991; Lapsley, 2008; Siverbo, 2004). Key to ABF is the separation of the roles of funder and provider, with the latter being accountable to the former. It rests on a logic of financial incentives and performance management to govern healthcare providers. By contrast, budgeting is rooted in traditional PA, where there is no need to separate between the roles of funder and provider. Providers are expected to act in the best interest of patients even in the absence of explicit rewards (or punishments) for good (or bad) performance (Cutler, 2002; Nuti et al., 2016). Where budgeting relies on discretionary, and sometimes arbitrary, decisions by the funder to reallocate funds across care providers, ABF implies an automated and transparent redistribution of resources based on reported activities and predetermined prices (Jegers et al., 2002). Where fixed budgets primarily give providers incentives to contain costs, ABF gives incentives to increase the volume of services, increase productivity, and report activities in administrative systems (Busse et al., 2011; Cutler, 2002; Lapsley, 2008; Palmer et al., 2014; Quentin et al., 2013).

We explore why and how ABF traveled across and within the 21 independent regional healthcare authorities, which are responsible for the funding and provision of public healthcare in Sweden. From the 1990s onward, 10 regions decided to complement or replace their traditional resource allocation models for hospitals—annual budgets based on historical costs—with DRG-based ABF (Anell, 1996; Gerdtham et al., 1999; Kastberg & Siverbo, 2007; Serdén & Heurgren, 2011). Eight regions later abandoned ABF and returned to traditional budgets, in some cases within a few years. The setting offers a unique opportunity to explore the entire journey of ABF—from the decision to adopt or reject to the decisions to sustain or abandon the control—in several similar PSOs operating within the same broad institutional context.

The adoption of ABF in Sweden (Anell, 1996; Charpentier & Samuelsson, 1996; Forsberg et al., 2001; Gerdtham et al., 1999; Kastberg & Siverbo, 2007) as well as in other countries (Busse et al., 2011; Kantola & Jarvinen, 2012; Palmer et al., 2014) has been extensively studied. Criticism against the adoption of ABF has focused on negative consequences for the professional autonomy of physicians and other staff due to a higher level of detail in the control system and also on the need for costly administration and risk of poor cost control (Forsberg et al., 2001; Kastberg & Siverbo, 2007; Quentin et al., 2013). However, there is scarce evidence on the decisions to sustain, abandon, or reject ABF altogether. A few case studies of a region in Denmark (Burau et al., 2018; Søggaard et al., 2015) and Sweden (Ellegård & Glengård, 2019; Glengård & Ellegård, 2018) have shed some light on the abandonment of ABF but have

different foci than the present study. The Swedish studies consider managers' perceptions of the consequences of the change in controls. The Danish studies describe the development of a new governance model, inspired neither by NPM nor traditional PA. The Danish case is an example of how NPM-inspired controls have come to be challenged by novel governance and management ideas, involving concepts such as collaboration, trust, co-creation, and co-production of public services, increasingly referred to as post-NPM (Hyndman & Liguori, 2016; Klenk & Reiter, 2019; Osborne, 2006).

We explore the journey of ABF across and within Swedish regions through the lens of diffusion theory. We make a twofold contribution to the literature on diffusion of practices. First and foremost, we develop a framework in which the abandonment or sustainment of a management control initiative is explained by the initial benefits from it and the propensity to continuously adapt the control. The initial benefits are determined by the adaptations made to make the control fit the context at the time of adoption (Ansari et al., 2010; Chandler & Hwang, 2015). The propensity to continuously adapt the control is determined by the interplay between the decision motive underlying the organization's initial decision to adopt (Kennedy & Fiss, 2009; Tolbert & Zucker, 1983) and the fits or misfits between organizational characteristics and properties of the control (Ansari et al., 2010; Ax & Greve, 2017). Second, we observe that the framing of decision motives differs between adopting and rejecting organizations, though not between early and late adopters as proposed in the literature (Abrahamson, 1991; Ax & Greve, 2017; Kennedy & Fiss, 2009; Tolbert & Zucker, 1983).

The next section outlines the theoretical framework used to guide our analysis of the journey of ABF across and within Swedish regions. We then describe the institutional setting, our empirical case, the analytical framework, and the results from our interviews with key informants from each Swedish region. Informed by our theoretical framework and empirical observations, we present a modified framework outlining avenues toward the sustainment or abandonment of a management control. We end the article by discussing the implications for theory and practice.

## 2 | THEORETICAL FRAMING

Our theoretical framing is inspired by Scandinavian institutionalism, which focuses on how and why practices are spread and translated in organizations as they diffuse in new settings (Ansari et al., 2010; Czarniawska & Joerges, 1996; Sahlin & Wedlin, 2008).<sup>1</sup> Motivated by our focus on the processes by which practices travel and are locally translated in adopting organizations, our analysis is guided by literature from the field of diffusion of practices, which addresses the questions *why* a management control initiative is adopted (Ansari et al., 2010; Ax & Greve, 2017; Kennedy & Fiss, 2009; Lapsley & Wright, 2004; Malmi, 1999; Laegreid et al., 2007; George et al., 2019) and *how* organizations adapt the control to fit organizational characteristics (Chandler & Hwang, 2015; Ansari et al., 2010).

According to existing diffusion theory models, the decision to adopt and sustain a management control may be motivated by perceived opportunities of *economic* or *social* gains or avoidance of losses (Abrahamson, 1991, 1996; Kennedy & Fiss, 2009; Tolbert & Zucker, 1983). *Economic* gains refer to improved technical efficiency from adoption, that is, better performance, while *social* gains refer to improved social legitimacy from adoption, that is, looking good from the perspective of stakeholders inside or outside the organization (Kennedy & Fiss, 2009). According to the traditional two-stage model of innovation diffusion, early and late adopters follow different *decision logics*: organizations that adopt early are motivated by economic gains, while organizations that adopt late are motivated by social legitimacy concerns (Tolbert & Zucker, 1983). Kennedy and Fiss (2009) modify the traditional two-stage model by adding the dimension of *issue interpretation*. Issue interpretation refers to *opportunity* or *threat* as framing of the possible adoption. Kennedy and Fiss (2009) argue that both early and late adopters may be motivated by perceived economic as well as social gains. Early and late adopters' views on benefits differ, however. Early adopters interpret benefits as perceived opportunities of economic or social gains. Late adopters instead adopt to avoid perceived threats of economic or social losses. Late adopters may benefit from learning from early adopters' experiences (Ansari et al., 2010; Chandler & Hwang, 2015). The reduced uncertainty surrounding the practice enables late adopters to carefully adapt the practice to fit their own organization. Chandler and Hwang (2015) characterise the type of learning an adopting organisation

is engaged in as more or less mindful. In organizations where a control is implemented *mindfully*, managers pay close attention to the potential consequences of using the control and adapt it to the context. This is opposed to less mindful implementations, where previous versions of the control are merely imported without deeper consideration.

## 2.1 | Organizational fit and decision to adopt or reject

Decisions to adopt a practice are also influenced by the fit between technical, political, and cultural characteristics of the organization and the inherent properties of the practice. Decision-makers may choose to adopt a practice despite a misfit in one or more of these dimensions but are then likely to adapt the control to their setting (Ansari et al., 2010).

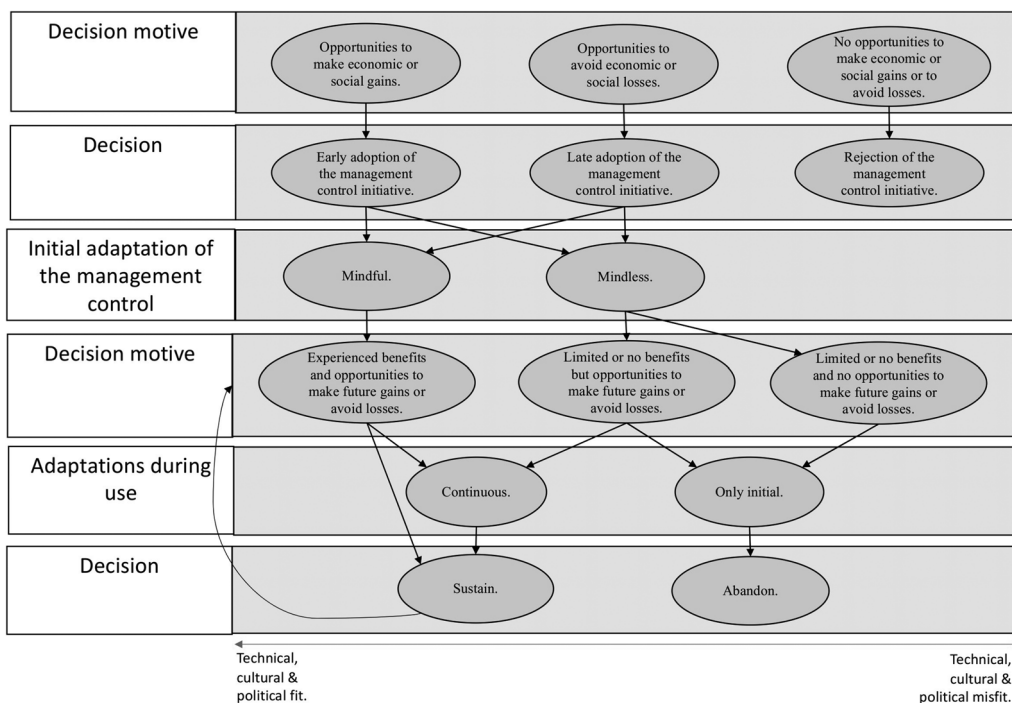
The technical fit between the characteristics of a control and the organizational capacity to implement it, for example, individuals' skills, objectives, and organizational structure and systems already in place, determines the *capability* to use a control practice (Ansari et al., 2010). Organizations that differ in their capabilities can neither be expected to adopt the same control nor to adapt it in a similar way. The *cultural fit* between organizational beliefs and culture and the characteristics inherent in a control practice determines the organization's *motivation* to adopt and sustain the practice (Ax & Greve, 2017). Cultural fit refers to the situation when the perceived cultural values and meaning structures embodied in a practice are compatible with beliefs and preferences within the organization (Ansari et al., 2010; Ax & Greve, 2017). A new practice will be recognized at an early stage in organizations where decision-makers believe that there is a cultural fit and will be adopted if it is perceived as delivering adequate gains. In organizations where the practice is incompatible with organizational culture and beliefs, the practice will be recognized late and only adopted if it is believed to help avoid losses (Ax & Greve, 2017). *Political fit* refers to the fit between normative claims and political loadings in the practice and, for example, interests, agendas of organizational members and political settlements within an organization (Ansari et al., 2010), which may influence the organization's *commitment* to use the control (Oliver, 1992).

## 2.2 | Initial and continuous adaptations

Technical, cultural, and political fits and misfits trigger different patterns of practice adaptation both initially (at the time of adoption) and over time (during the period of use; Ansari et al., 2010). Such adaptations imply that an adopted control practice will differ in fidelity, that is, the extent to which it deviates from the features of the previous version of the practice, and extensiveness, that is, the comprehensiveness of its implementation in the organization. A "true and full adoption" refers to a situation where a practice is implemented with greater fidelity, compared to previous versions, and in a far-reaching manner (Ansari et al., 2010). Notably, a mindful adaptation does not by itself indicate the degree of fidelity or extensiveness of the adopted practice; mindfulness only denotes the extent to which a practice is adapted to fit the local context.

The journey of a management control within an organization can be regarded as a series of decisions to either abandon it or sustain it, potentially after making adaptations in response to fits and misfits. We propose that decisions to sustain or abandon a control practice are related to perceived benefits of the practice, which in turn are related to *why* organizations adopt new practices and *how* they adapt it to fit the organization's technical, cultural, and political characteristics. A practice will be sustained as long as decision-makers experience it as beneficial for the organization, that is, as long as it is believed to help fulfill organizational goals, or to have the potential to do so (Abrahamson, 1991; Kennedy & Fiss, 2009; Lapsley & Wright, 2004; Tolbert & Zucker, 1983). We propose that organizations that have the capacity, motivation, and commitment to use the practice, that is, where there is a good fit (Ansari et al., 2010), and that adapt the control mindfully at the time of adoption are more likely to experience benefits from its initial implementation (Chandler & Hwang, 2015).

No matter how well a control is adapted to fit the prevailing context and organizational goals at the time of adoption, it may lose its fit as circumstances change (Ansari et al., 2010). This is not least relevant in PSOs, where new



**FIGURE 1** Theoretical framework to analyze motivations for adopting or rejecting and sustaining or abandoning management controls.

goals are continuously added to old ones as the political agenda changes (Brunsson, 2006; Cutler, 2002). To reach (new) organizational goals and balance old and new ones, managers may have to adapt existing control practices and alternatively adopt new ones (Ansari et al., 2010; Bevan et al., 2010; Cutler, 2002). We tentatively propose that it may be useful to distinguish between organizations that only adapt the practice *initially*, at the time of adoption, and organizations that engage in *continuous* adaptations of adopted practices. We propose that continuous adaptations are critical for the sustainability of a practice in the face of new organizational goals and circumstances and that such adaptations are more likely in organizations with both capability and motivation (Ansari et al., 2010; Ax & Greve, 2017) and commitment (Ansari et al., 2010; Oliver, 1992) to use the practice, that is, where there is a technical, cultural, and political fit between organizational characteristics and properties of the control. Figure 1 summarizes our theoretical framework to explore decisions to abandon or sustain a management control initiative in light of previous and novel decision motives and fits and misfits. The upper three rows illustrate the path leading up to the decision to adopt or reject, and the lower three rows illustrate the ongoing appraisal of the control once adopted. Crucially, the initial decision can only be motivated by expectations, whereas later decisions are also informed by experiences.

### 3 | INSTITUTIONAL BACKGROUND

The responsibility for financing and organizing healthcare in Sweden is decentralized to 21 independent regional authorities. Each region has a council of political party representatives, elected in proportional elections held every fourth year. The regions have the right to tax their citizens using a proportional income tax, and each council sets its own tax rate. The tax accounts for around 70% of healthcare financing; the rest is covered by user fees and equalization grants from the central government. The general principles for allocating resources across hospitals are determined

by a regional board constituted by politicians, based on detailed decision guidance documents prepared by civil servants. Across regions, there are formal and informal networks where politicians and civil servants share experiences on matters regarding the organization and governance of healthcare (Anell et al., 2012).

There are seven university hospitals and about 70 regional hospitals, which provide inpatient and outpatient services. Six of the regional hospitals are private (three for-profit, three non-profit). All university hospitals and two-thirds of the regional hospitals provide full emergency services. The other hospitals have a narrower scope, for example, elective surgery. There is at least one full emergency hospital in each region. All hospital staff are salaried employees.

Before the 1990s, all regions used fixed budgets based on historical costs to allocate resources to hospitals, and they had limited possibilities to monitor provider activities. The development of a Nordic DRG system (Nord DRG) from the early 1990s onward enabled regions to better describe hospital activity (Anell, 1991; Serdén & Heurgren, 2011). The Nord DRG system classifies patients into different groups based on their medical condition (diagnosis), severity (complex/non-complex), and mode of treatment (inpatient/outpatient care). While all Swedish regions use the Nord DRG system to describe and monitor the performance of providers, only 10 of the regions have ever used DRGs as the basis of ABF (Ellegård & Glengård, 2019; Glengård & Ellegård, 2018; Serdén & Heurgren, 2011).

The design of the ABF model may vary in several aspects. First, DRG-weighted activity can be used to allocate resources retrospectively (in response to volumes of care produced the current year) or prospectively (to inform the budget for the upcoming year). The prospective model implies that the payment is activity-based with a lag, while it effectively functions as a fixed budget during the current year. Second, the measuring of activity and allocation of funds can be at the hospital level or at a lower level (e.g., clinic). Third, the share of total payments that is activity-based may vary. It is common to use ABF as a complement to a fixed budget (Busse et al., 2011).

ABF requires more technical capacity to operate, compared to budgets based on historical costs. The DRGs develop over time, following the medical development, as does the relative weight of each DRG (DRG points). This means that the region has to make annual adjustments of the details of the funding model and that frontline medical staff need continuous training to classify patients correctly. Furthermore, DRG-based ABF requires that each DRG is assigned a price tag. The Swedish regions normally base the prices on the national average costs within a given DRG, but if the region is not content with the incentives provided by the average cost reimbursement, it has to manually change the prices for individual DRGs.

Table 1 presents the characteristics of the regions. Some of these characteristics indicate how well ABF would fit in the regions. Reforms and adoption of control initiatives tend to vary in timing and extent across the country, depending on local contextual factors and political priorities (Anell et al., 2012). During the first half of the 1990s, about half of the regions implemented purchaser–provider splits (Anell, 1996; Gerdtham et al., 1999; Siverbo, 2004).<sup>2</sup> Such an early adoption of purchaser–provider split models indicates both a technical capacity to administer ABF and cultural and/or political fit, in terms of a history of being open rather than closed (Ansari et al., 2010) toward market-inspired management control initiatives (Siverbo, 2004). Larger size and more hospitals indicate a better technical fit with ABF. Larger size is positively associated with the adoption of management controls in PSOs and a better administrative capacity in general (Carvalho et al., 2012; George et al., 2019). The presence of several hospitals, or at least hospital sites, is a prerequisite to benefit from the idea of (re)distributing resources between hospitals or clinics according to their activity, an important feature of ABF (Busse et al., 2011; Jegers et al., 2002). The political parties are usually divided into center-right-wing or center-left-wing blocks. Center-right-wing blocks indicate a better political fit with the normative claims of ABF than center-left-wing blocks due to the market-inspired properties of ABF. However, often parties cooperate across block boundaries and the political majority has shifted over time in many regions.

**TABLE 1** Characteristics of regions.

Region	Region size <sup>a</sup>	No. of hospitals in region	Political majority 1991–2022	Early introduction of purchaser-provider-split <sup>d</sup>
1	Small	1	Center-left except 2018–2022	No
2	Small	5	Center-left except 2018–2022	Yes (1991)
3	Small	1	Shifting	No
4	Small	6	Center-left	Partly (1993)
5	Small	1 (three sites)	Center-right	No
6	Small	1	Center-left except 2018–2022	No
7	Small	3	Shifting	No
8	Small	3	Center-left	No
9	Small	2	Shifting	No
10	Small	5	Center-left except 2018–2022	No
11	Large	8 <sup>b,c</sup>	Shifting	Partly (1993)
12	Large	8 <sup>b,c</sup>	Center-right except 1994–1998 and 2002–2006	Yes (1992)
13	Small	3	Center-left	Yes (1993)
14	Small	2 <sup>b</sup>	Shifting	Partly (1992)
15	Small	3	Center-left, except 2014–2022	No
16	Small	3	Center-left	Partly (1993)
17	Small	3	Center-left except 2010–2014 and 2018–2019	No
18	Small	4	Center-left	No
19	Large	8 <sup>b,c</sup>	Shifting	Partly (1993)
20	Small	3 <sup>b</sup>	Shifting	Yes (1993)
21	Small	3 <sup>b</sup>	Center-left	Partly (1993)

Note: The borders of Regions 6, 11, and 19 have merged/changed since 1991. We have used the geographical borders of current regions in the table.

<sup>a</sup>Large = > 1000 inhabitants; small = < 500 inhabitants.

<sup>b</sup>There is a university hospital in the region.

<sup>c</sup>There is at least one private hospital in the region.

<sup>d</sup>The regions adopted a purchaser–provider split model during first half of the 1990s (Anell, 1996; Gerdtham et al., 1999).

## 4 | METHODS

Our empirical study had an explorative onset. We use the theoretical framework to describe and understand the empirical trajectories rather than to test a hypothesis. We use both secondary and primary data to explore the use of DRG-based ABF in all Swedish regions during 1992–2020.

## 4.1 | Data

Each year, the National Board for Health and Welfare (NBHW) collects data about the regions' use of DRG to monitor and allocate resources to hospitals through a survey of all regions. We used these data to gain an initial understanding about the use of DRG-based ABF in each region during the study period and to inform our collection of primary data.

Our primary source of data consists of interviews with civil servants with long experience of the hospital payment models in their region. We obtained contact information from relevant respondents in each region from the author of a Swedish report on provider payment models (Peter Lindgren, personal communication, October 27, 2018). Respondents from each region were invited to participate in a semi-structured telephone interview. All respondents held senior management positions equivalent to senior controllers or chief financial officers. The invitations were sent by e-mail in April 2019, with two reminders. Representatives from all but one region agreed to participate. All interviewees were informed that participation was voluntary and that they could discontinue the interview at any time. We attached seven questions to the invitation mail:

1. In what way and during which periods have you used ABF, and in what way do you plan to use ABF in the next couple of years?
2. Why did your region adopt/reject ABF?
3. Did you gather information about experiences from other regions when adopting/rejecting/adapting ABF?
4. Why did your region abandon/sustain ABF?
5. In what way and during which periods have you used DRGs to describe hospital activity?
6. In what way and during which periods have you used DRGs to monitor and follow up on provider activities?
7. In what way and during which periods have you used DRGs to set upcoming budgets?

The questions were open and neutral in character. We did not ask explicit questions about decision logic, technical, cultural, or political fit but allowed the respondents to answer based on their understandings and beliefs of the subject. Twenty-eight key informants participated in phone interviews and answered the questions via e-mail or both (Table 2). All interviews lasted between 25 and 37 min. Some region representatives provided documents to support and clarify their answers. In some cases, we made follow-up interviews to clarify and add information to initial findings, in particular when we needed to complement with information about events that happened before the interviewee started working in the region (12 and 19), and when we were notified about changes in the payment model that had occurred after the first interviews (12 and 5). Hence, there were one to four informants and one to three interviews per region. During the interviews, we made careful notes to each question. We use pseudonyms (numbers) to anonymize regions.

## 4.2 | Analysis

Our empirical material allows us to study how and why ABF traveled across and within regions. We used directed content analysis (Hsieh & Shannon, 2005) to thematically analyze the interview data with reference to our theoretical framework (Figure 1). First, we reviewed the survey data from the NBHW and our interview data (Question 1) to comprehend the design of the regional ABF models and the years of use. In the rare cases when the informants expressed that the survey data were wrong, for example, that it indicated that ABF had been used in years when it had not, we gave interview data precedence over the survey data. Second, we used answers to interview Questions 1–4 to describe and understand the motives for adoption or rejection, how adopting regions adapted and used the practice, and why they abandoned or sustained ABF.<sup>3</sup>

Table 3 shows the concepts in the theoretical framework linked to each research question. Some concepts, for example, technical efficiency (better performance, e.g., better monitoring and higher productivity) and social legiti-

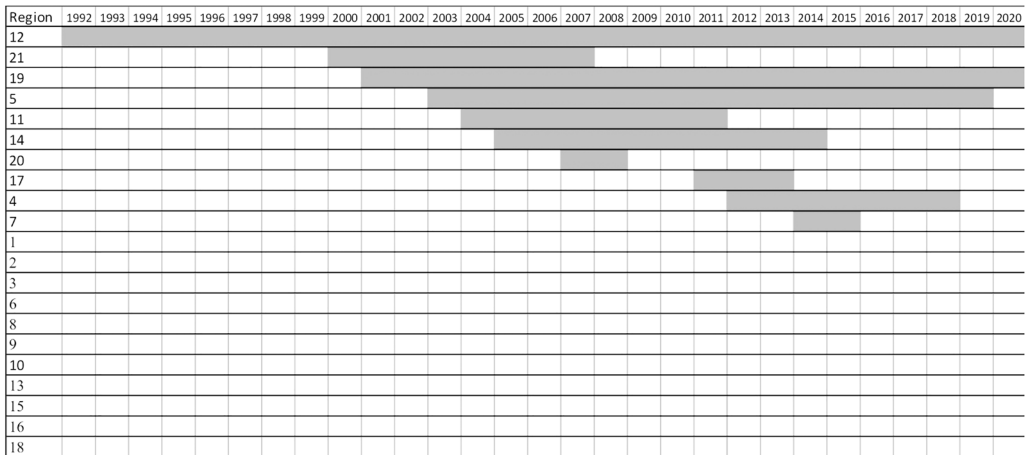


**TABLE 2** Primary data collection.

Region	No. of respondents	No. of phone interview(s)	Answered questions by e-mail
1	One	One	No
2	One	None	Yes
3	One	One	No
4	One	One	No
5	Two	Three	No
6	One	None	Yes
7	Two	Two	Yes
8	One	One	No
9	One	None	Yes
10	One	One	No
11	Three	Two	No
12	Four	Three	Yes
13	One	None	Yes
14	One	Two	No
15	One	None	Yes
16	One	One	No
17	One	One	No
18	One	One	No
19	Two	One	No
20	No	None	No
21	One	One	No

**TABLE 3** Analysis of empirical material.

Theme	Research question	Concepts
Motives for adopting or rejecting the control	What were the decision motives behind adoption or rejection of activity-based funding (ABF)?	Technical efficiency (T) Social legitimacy (S) Technical fit Political/cultural fit
Adaptation of the control	How did the adopting regions adapt ABF to fit organizational goals and characteristics?	Mindful/mindless Continuous/Initial
Use of the control	How did the adopting regions use ABF?	High/low fidelity High/low extensiveness
Motives for sustaining the control or returning to the old practice	What were the decision motives behind sustaining or abandoning ABF (return to fixed budgets)?	Technical efficiency (T) Social legitimacy (S) Technical fit Political/cultural fit



**FIGURE 2** Use of diagnosis-related group-based activity-based funding in Swedish regions 1992–2020.

macy (e.g., increased fairness, improved transparency), related directly to the decision motives stated in the interviews. For other concepts, for example, mindfulness, fit, fidelity, and extensiveness, we classified regions as follows.

The adoption of ABF was classified as mindful if the design of the model acknowledged context-specific features, and the model was adapted accordingly at the time of adoption (initial) and/or in response to new circumstances and changing organizational objectives (continuous). Technical fit was judged by the capability to use ABF, that is, the access to adequate administrative capacity and the number of hospitals. The number of hospitals can be regarded as indicating technical fit in our setting, as the studied management control partly builds on the possibility to reallocate resources between hospitals or hospital sites.

We did not separate between cultural and political fit in the analysis. Cultural and political characteristics are intertwined in PSOs, and it is difficult to disentangle the political loadings and meaning structures embodied in ABF; the separation of payers and providers, the use of financial incentives to guide behavior, the clear linkages between production and payment and the good opportunities to hold providers to account for their actions are part of the practice itself. Political/cultural fit was judged by the motivation and commitment to use ABF, that is, decision-makers' perceptions about the appropriateness of the political loadings and meaning structures embodied in ABF to realize political priorities and meet organizational values and objectives.

We distinguished between high and low fidelity based on how the model was used: High fidelity means that hospitals were allocated resources retrospectively based on their current volumes of care; low fidelity means that the current volumes were used to inform the budget for the next year. The degree of extensiveness relates to the proportion of ABF in the total payment to hospitals.

## 5 | RESULTS

Figure 2 gives an overview of the use of ABF by region and year during 1992–2020. In 1992, Region 12 was the first to adopt DRG-based ABF. The number of regions using the control practice increased until 2007, when seven regions used ABF. Thereafter, the number started to decrease, although some regions adopted the practice later. By 2020, two regions still used ABF. Although the total number of regions using ABF did not exceed seven in any given year, a total of 10 regions used the control practice at least 2 years during the study period. While Region 12 can be described as a pioneer, the first real wave of adoption started in the early 2000s, when six regions adopted ABF. The second wave included three regions that adopted ABF 2011–2014. Three regions abandoned the practice quickly (after 2–3 years) and five after a relatively long time (7–17 years).

The institutional details in Table 1 suggest that the decision to adopt or reject ABF may relate to technical and political/cultural fit. Nine out of the 12 regions that were governed by primarily center-left majorities rejected ABF, whereas the two regions with a primarily center-right majority adopted ABF and sustained it throughout (Region 12) or for a relatively long period (Region 5). Seven regions (12, 19, 21, 11, 14, 20, 4) out of the 10 that adopted ABF had previously adopted another market-inspired control, that is, a purchaser-provider split. The interviewees in six of those seven regions (14 was the exception), mentioned that there was a technical fit between ABF and the administrative systems in place. By contrast, eight out of 11 non-adopting regions had not implemented a purchaser-provider split. Of the three adopting regions with no history of a purchaser-provider split, respondents in two (5, 7) mentioned that the model had a technical misfit in terms of the number of hospitals and limited administrative capacity. These two regions were governed by either center-right (5) or shifting (7) political majorities. The respondent from the third region (17) mentioned that there was a technical fit but political/cultural misfit. This region was mainly governed by center-left majority.

To further the understanding of decisions to adopt or reject ABF, the next section describes the common motives for rejecting the control as stated in the interviews. We then turn to the interview results from the adopting regions to describe the decision motives and the journey of ABF.

## 5.1 | Motives for rejecting ABF

The 11 regions that never adopted DRG-based ABF gave similar motives for rejecting the control. The first motive reflects a technical efficiency decision logic: With cost containment being the most important objective, the incentives embodied in ABF were perceived as counterproductive.

We have been struggling with budget deficits for years and implementing ABF would only make it worse. (Region 10).

Several respondents mentioned a *political/cultural misfit* between their organizational values and the normative claims inherent in ABF as a motive for not adopting the practice. Instead, a logic of traditional PA was emphasized:

We have considered ABF, but the region is very traditionally governed. We have a very strong budget tradition [...], and there has always been a consensus about the problems associated with variable payments. (Region 16)

Finally, several respondents mentioned *technical misfit*. The regions had too few hospitals and/or a limited administrative capacity:

We thought about implementing DRG-based payment but did not have the administrative capacity. Our region is too small. (Region 8)

## 5.2 | Regions that adopted ABF

Table 4 gives an overview of our findings from the interviews in adopting regions. We summarize the decision motives for adopting ABF in the next subsection. We then draw on the empirical observations to describe the use and possible determinants of the sustainability of the control. We end the results section by presenting a modified theoretical framework, grounded in our empirical observations, which outlines possible avenues to abandoning or sustaining a management control.

**TABLE 4** Overview of decision motives and fit/misfit with diagnosis related group (DRG)-based ABF in adopting regions.

Region (Period of use)	(1) Decision motives for adoption ABF <sup>a</sup>	(2) Adaptation	(3) Fidelity and extensiveness in use <sup>b</sup>	(4) Decision motives for sustaining ABF	(5) Decision motives for returning to budgets <sup>a</sup>	(6) Fit/misfit with ABF	(7) Avenues to sustain or abandon ABF <sup>c,d</sup>
12 (1992–)	T: Productivity T: Monitoring T/S: Fairness	Mindful, continuous	High fidelity <sup>c</sup> 50%–100%	T: Productivity T: Monitoring T/S: Fairness	N/A	Technical fit Political/cultural fit	S1, S2
19 (2001–)	T: Productivity T: Monitoring	Mindful, continuous (minor)	Low fidelity 20%–40%	T: Productivity T: Monitoring	N/A	Technical fit Political/cultural misfit from start	A3 (predicted)
21 (2000–2007)	T: Monitoring T/S: Fairness	Mindful, continuous (minor)	High fidelity 10%	N/A	No perceived additional benefit with ABF.	Technical fit Political/cultural misfit from start	A3
5 (2003–2019)	T: Productivity T: Monitoring T/S: Fairness	Mindful, initial	Low fidelity 100%	N/A	T: Efficiency/ effectiveness T: Administration	Technical misfit Political/cultural fit	A2, A6
11 (2004–2011)	T: Productivity T: Monitoring T/S: Fairness	Mindful, continuous (minor)	High fidelity 40%–60%	N/A	T: Efficiency/ effectiveness T: Innovations	Technical fit Political/cultural misfit over time	A1, A5
14 (2005–2014)	T: Productivity T: Monitoring	Mindful, continuous	High fidelity 40%–70%	N/A	T: Efficiency/ effectiveness T: Innovations T: Administration	Technical misfit Political/cultural misfit over time	A2

(Continues)

TABLE 4 (Continued)

Region	(1)	(2)	(3)	(4)	(5)	(6)	(7)
(Period of use)	Decision motives for adoption ABF <sup>a</sup>	Adaptation	Fidelity and extensiveness in use <sup>b</sup>	Decision motives for sustaining ABF	Decision motives for returning to budgets <sup>a</sup>	Fit/misfit with ABF	Avenues to sustain or abandon ABF <sup>d</sup>
20 (2007–2008)	No data	No data	No data	No data	No data	No data	
17 (2011–2013)	T: Monitoring	Mindful, initial	Low fidelity 100%	N/A	T: Efficiency/effectiveness	Technical fit Political/cultural misfit from start	A3
4 (2012–2018)	T: Productivity T: Monitoring T/S: Transparency	Mindful, initial	Low fidelity 90%–100%	N/A	T: Efficiency/effectiveness T: Administration	Technical fit Political/cultural misfit from start	A3, A7
7 (2014–2015)	T: Productivity T: Monitoring T/S: Transparency S: External pressure	Mindless, initial	Low fidelity 100%	N/A	T: Efficiency/effectiveness T: Innovations	Technical misfit Political/cultural misfit from start	A4, A8

<sup>a</sup> T = Technical efficiency opportunity; S = Social legitimacy opportunity.

<sup>b</sup> High fidelity = Retrospective payment based on care volume (DRG points) in the current year. Low fidelity = budget for the next year set based on care volume (DRG points) in the current year. Extensiveness = ABF as share of total payment according to interviewees.

<sup>c</sup> Except 2016–2019, when the region used a low-fidelity ABF model to facilitate task-shifting reforms.

<sup>d</sup> Avenues to sustain or abandon DRG-based ABF are explained in Figure 3.

### 5.2.1 | Motives for adopting ABF

Respondents from all adopting regions framed the adoption as an opportunity to make gains, not as a way to avoid losses. All respondents from adopting regions explicitly mentioned decision motives along the lines of technical efficiency and/or social legitimacy opportunities. We identified four motives (column 1, Table 4):

1. Opportunities of better *monitoring of provider activities*. All respondents mentioned that—at the time of adoption—there was a strong political will to improve the monitoring of hospitals to be able to hold providers accountable. It was believed that financial incentives to improve documentation and reporting would facilitate the monitoring.
2. Opportunities of higher *productivity and/or volume of services*. Respondents in seven (12, 19, 5, 11, 14, 4, 7) of the 10 adopting regions explained that—at the time of adoption—policymakers wanted to shorten waiting times and increase productivity.

We wanted to stimulate increased production because of long waiting times. The change to ABF put focus on production, which also increased. (Region 12)

3. Opportunities of increased *fairness* in the distribution of resources. The respondents in four adopting regions (12, 21, 5, 11) mentioned that they wanted to strengthen the link between payment and activity. These regions wanted to facilitate and be able to better defend and motivate the allocation of resources across hospitals or sites.

We wanted to improve our monitoring and create a better link between payment and activities. (Region 5)

4. Opportunities of improved *transparency* in priority settings. Respondents from two regions (4, 7) explained that they wanted to facilitate the implementation of political priorities. The idea was that ABF would enhance the transparent implementation of political priorities by attaching higher DRG points to highly prioritized areas.

The motive was that it would support political goals and priorities. To give prioritized areas and treatments more points. More focus on some activities and less on other. (Region 4)

The respondents mentioned several aspects related to fit/misfit with ABF in their region when they described why the control was adopted and how it was adapted and used (column 6, Table 4). Such aspects were, for example, administrative capacity (an instance of technical fit) and political commitment to use ABF to incentivize providers (political/cultural fit). There was only one region in which the informant mentioned motives corresponding to a social legitimacy logic vis à vis external stakeholders:

Everyone else adopted DRG, so we did too. We went from traditional fixed budgets straight into ABF. It had a lot to do with pressure from others. (Region 7)

### 5.2.2 | Adaptations of the control

From the respondents' descriptions of the ABF models, the control tended to be mindfully rather than mindlessly adopted (columns 2–3, Table 4): There was substantial variation in fidelity, ranging from true ABF, in which current activity was reimbursed retrospectively (high fidelity), to models with prospective payments based on last year's activity measured by DRGs (low fidelity). The extensiveness, that is, the share of funding that was related to activity, also varied from 10% (low extensiveness) to 100% (high extensiveness).

With its technical and political/cultural fit and high fidelity and extensiveness of their practice, Region 12 can be seen as an enthusiastic pioneer (Charpentier & Samuelsson, 1996). Assignments to providers were expressed in DRG points at the hospital level, and the payment was retrospective. The initial model lacked ceilings for costs or volumes. Such ceilings were introduced 3 years after adoption as a response to an overproduction of services and higher costs than expected.

In all other regions, there was a variation in regard to fits and misfits, and the use of ABF was characterized by lower fidelity and/or extensiveness. Several respondents from other regions contrasted their use of ABF to that of Region 12 when asked to describe their own model, specifically to point out how the use in their own region was more modest:

We used ABF in our own way, not like [Region 12] [...] more as a tool to set budgets based on last year's production as measured by DRG points, not to pay providers retrospectively. (Region 5)

We use DRG-based payment more as a complement to fixed prospective budgets. 20%–40% of total payment to providers. Only at the hospital level, never at the clinic level as they do in [Region 12]. (Region 19)

The two regions that still used ABF at the end of the study period (12 and 19) were both large and had the administrative capacity required to maintain a detailed model (technical fit). However, where Region 12 was devoted to ABF (political/cultural fit), Region 19 appeared more skeptical to the philosophy behind ABF and employed a model with low fidelity and low extensiveness. The respondents from Region 12 expressed that there is a strong political commitment to use ABF to incentivize providers and maintain clear linkages between activity and payment. The respondents from Region 19 were reluctant to describe their use of ABF in terms of financial incentives for providers. They described their work with agreements as more important. The practice resembles more of a fixed payment without clear linkages between activity and payment in the current year.

We really use DRGs more to estimate the budget for the upcoming year than to allocate resources retrospectively. [...] We know how much money is available for the upcoming year and then we count backwards and allocate money to each hospital with some margin. (Region 19)

### 5.2.3 | Sustainability of the control

Our interviews indicate that the sustainability of ABF relates to how it corresponds to the initial decision motives and to opportunities to make future gains.

Both regions that sustained ABF throughout commented that they experienced the expected benefits in relation to their technical efficiency objectives, that is, high productivity and efficient monitoring (12, 19) and social legitimacy goals, that is, a fair distribution of resources (12) (column 4, Table 4).

The regions that abandoned ABF mentioned a lack of opportunities to make future gains by using ABF, that is, they saw better opportunities to make future gains by returning to fixed budgets (column 5, Table 4) and/or organizational misfit with ABF (column 6, Table 4). Most abandoning regions referred to issues of technical efficiency in relation to novel objectives; for instance, some mentioned that ABF was counterproductive in relation to the emerging goal to treat more patients in an outpatient setting since the ABF reimbursement was higher for inpatient treatments (Regions 4, 5, 11, 14). The control also itself led to technical inefficiencies; for instance, the administration of ABF was seen as burdensome, in particular for small regions (4, 14), and one region experiences incompatibility issues between administrative systems, that is, technical misfit (Region 7). Another region (17) mentioned unintended consequences, that is, incentives to upcode or code too many diagnoses or procedures, as a reason for abandoning the practice. There was a view that DRGs should be used only to monitor provider activities but not to allocate resources:

We see the benefits of separating the description of activities [with DRGs] from payment—to use the DRG system the way that it is intended. It leads to more accurate reporting. (Region 17)

Respondents from two regions (4, 7) mentioned political/cultural misfit as a reason behind the decision to abandon ABF. The decision motive of a more transparent priority setting did not materialize due to a lack of political commitment to act in accordance with the intentions behind the adoption (i.e., to make transparent priorities and translate those into DRG points):

We wanted to facilitate the reallocation of resources to politically prioritized areas, but we did not get what we wanted. [...] This was not an administrative issue but a political. (Region 4)

The propensity to make continuous adaptations of the control in response to changing circumstances emerged as an important factor linked to the opportunity to benefit from ABF and, hence, to the sustainability of the control. Of the regions that only adapted the control around the time of adoption (4, 5, 7, 17), all but one region sustained ABF for less than 7 years. The exception is Region 5, which sustained ABF for 19 years. By contrast, the regions that continuously adapted the control (12, 19, 21, 11, 14) sustained ABF for a relatively long time (at least 7 years). The adaptations were typically minor variation in extensiveness, for example, introducing caps or making small adjustments of the share of ABF (typically  $\pm 10\%$ ; see Table 4, column 3). The exception was again in Region 12, where the extensiveness and fidelity varied significantly over time.

The results from the interviews suggest that the propensity to continuously adapt the control practice in light of new circumstances was related to organizational fit. The two regions that sustained their use of ABF (12, 19) are both characterized by technical fit in terms of adequate administrative capacity and several hospitals. Region 12 is also characterized by a political/cultural fit and has implemented significant changes in response to new objectives and circumstances to continue to benefit from ABF. Since adoption, the share of ABF has varied between 50% and 100%, with various ceilings for costs and volumes. During 2016–2019, the region temporarily used budgets based on historical care volumes (in DRG points) to facilitate a large restructuring of the organization. The perception from the interviews was that there is a strong political commitment to use ABF. On the other hand, Region 19 is characterized by a political/cultural misfit with ABF but has nevertheless sustained it. The region initially adapted the practice (low fidelity and extensiveness) to make it consistent with their organizational values. Thereafter, decision-makers in the region have regularly evaluated the payment model and concluded that the mix of fixed budgets and ABF fulfills the objectives of improved monitoring of providers, accessibility, and productivity of hospital care while maintaining a fair cost control. The objectives of the region have not changed substantially, and there has thus not been a need to make significant continuous adaptations to benefit from the control.

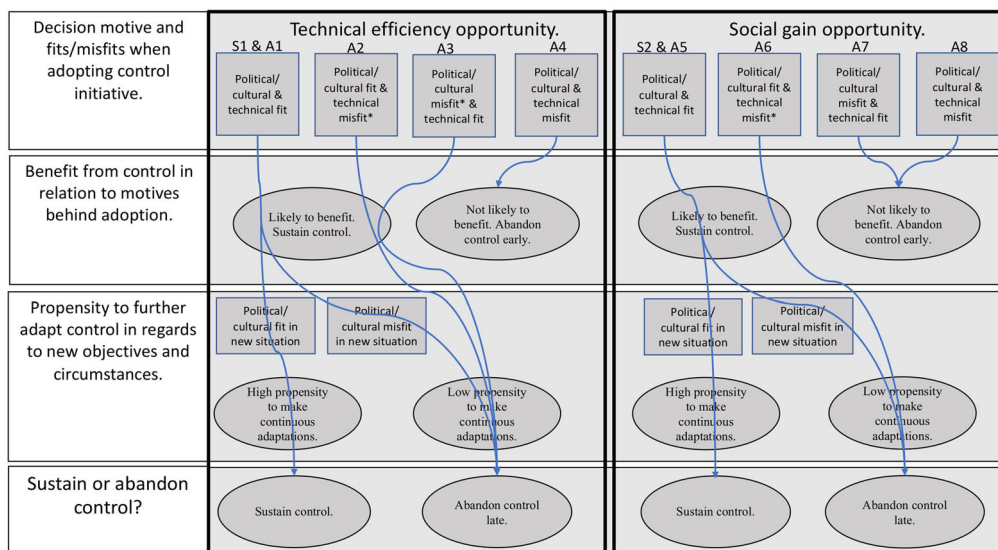
Among the regions that abandoned ABF (4, 5, 7, 11, 17, 14, 21), there was no consistent pattern regarding technical fit. With regard to political/cultural fit, with one exception (5), the respondents from all regions that abandoned ABF indicated a political/cultural misfit with the practice from the outset (4, 7, 17, 21) or over time (11, 14).

There has never been any doubt regarding political direction here. [Region 21] is a fixed-budget-region. (Region 21)

In Regions 11 and 14, the practice lost its political/cultural fit as new political priorities and organizational objectives gained importance. There was a shift in emphasis, from a focus on volumes of specific activities to a desire for increased innovativeness and flexibility and enabling decisions at hospitals based on professional autonomy rather than external incentives.

The hospitals should have a budget and then allocate in the most appropriate way. [The return to budgets] was intended to give providers more flexibility to make decisions based on professional expertise. (Region 14)





\*In case of misfit, mindful adaptation is required to benefit from control.

**FIGURE 3** A framework to understand the sustainment or abandonment of a management control in public sector organizations. [Colour figure can be viewed at wileyonlinelibrary.com]

In Region 5, the political/cultural fit remained throughout the period of using ABF. However, there was a technical misfit from the outset. At the time of adoption, Region 5 carefully adapted the control practice to fit the context and capacity of a small region with only one hospital, operating at three sites. The use of ABF led to improved reporting and a closer match between volumes of care and allocation of resources across sites. However, as medical technologies developed, the ABF model was increasingly perceived as an obstacle in relation to the objective of producing more care in a daycare setting. The interviewee, who was the only person in charge of designing the system, did not have enough time to make detailed adjustments of prices needed to fix these incentives. Region 5 reintroduced fixed budgets based on historical costs in 2020.

### 5.2.4 | A modified framework

The empirical observations indicate that some aspects of our theoretical framework (Figure 1) were not relevant to understand the decisions to sustain or abandon a control, once adopted. There was only one region (7) in which the adoption could be characterized as mindless. Generally, the control was mindfully adapted to align with the prevailing organizational objectives and characteristics. Furthermore, decision motives in all adopting regions—early as well as late—were framed as an opportunity to make gains, not as a way to avoid losses. Hence, we develop a modified framework that does not separate between mindful or mindless adoption, loss or gain motive, or early and late adopters (Figure 3).

The timeline at the right vertical axis of the modified framework is drawn to distinguish between sustainability in the short run (i.e., given the initial objectives and circumstances) and in the long run (i.e., following changed objectives or circumstances). In line with established theories of diffusion (Abrahamson, 1991; Kennedy & Fiss, 2009; Tolbert & Zucker, 1983), we distinguish between technical efficiency motives (e.g., better monitoring, higher productivity, and activity) and social legitimacy motives (e.g., increased fairness, improved transparency). Moving down the figure, the second row shows how the sustainability of the control relates to the perceived benefits given the original decision motives and organizational fit. The third row characterizes the organization’s propensity to engage in continuous

adaptions following the emergence of new objectives and circumstances, and the fourth row shows the sustainability of the control given the new situation.

The arrows in Figure 3 outline two avenues to sustaining (S1 and S2) and eight avenues to abandoning (A1–A8) ABF grounded in our empirical observations. To see which avenue(s) each study region followed, see column 7 of Table 4. Note that it is possible to follow one avenue in each silo, as both technical efficiency and social legitimacy motives may prevail in a given organization.

The avenues followed by the two polar cases Region 12 and Region 7 (S1 and S2; A4 and A8) illustrate that a technical and political/cultural fit may predict sustainability (Region 12) and conversely how misfit in both dimensions may predict early abandonment (Region 7).

Avenues A2 and A6 illustrate that a political/cultural fit can facilitate the initial adaptations necessary to overcome a lack of technical fit (e.g., allocating time and resources to the design of the control), and thus make the organization enjoy the initial expected benefits of the control. For instance, the practice was sustained for a long time in the small—technically unfit—Region 5. Yet, the political/cultural fit was not enough to overcome the consequences of the technical misfit as novel objectives emerged and the region therefore abandoned the control.

The type of decision motive (technical efficiency or social legitimacy) plays a role in the event of low political/cultural fit. Specifically, even if there is political/cultural misfit, the control may deliver the intended benefits that are related to technical efficiency (such as the goals to improve monitoring and increase activity, Regions 17, 19, 21) (A3). On the other hand, a lack of political/cultural fit may inhibit the opportunity to reach social legitimacy objectives, as exemplified by Region 4's failure to achieve a more transparent priority setting (A7). The propensity to further adapt the control in regards to new objectives and circumstances is low if the motivation and commitment to use the control is lacking, even if the organization is technically capable to adapt it to the new situation.

The political/cultural fit may also change over time. To illustrate, ABF lost its political/cultural fit in Regions 11 and 14 as they started to place more value on flexibility and innovativeness. As the regions did not consider it feasible to adapt the ABF to accommodate the new goals, they decided to abandon the control (Region 11: A1 and A5; Region 14: A2).

Region 19 has sustained ABF despite a political/cultural misfit. The main objectives in this region have not changed since the time of adoption, so the need for substantial continuous adaptations has not yet arisen. Region 19 is still principally at the second step of the framework, and we predict that the underlying political/cultural misfit would make Region 19 more likely to eventually abandon than to implement significant adaptations if new objectives or circumstances arise ABF (A3 (predicted)).

## 6 | DISCUSSION

We observe differences in decision motives (Kennedy & Fiss, 2009; Tolbert & Zucker, 1983) and organizational fit between organizational characteristics and properties inherent in ABF (Ansari et al., 2010; Ax & Greve, 2017) between rejecting and adopting regions. Regions that rejected ABF often framed their decision in terms of avoiding a loss, namely, a loss of control over the growth of healthcare costs. Adopters, by contrast, framed their decision in terms of an opportunity to make gains related to technical efficiency and/or social legitimacy. This difference in issue interpretation has a theoretical analogue to the distinction between early and late adopters outlined by Kennedy and Fiss (2009). Notably, however, like Kantola and Järvinen (2012), we do not find any differences between early and late adopters in terms of the issue interpretation. This may relate to the study setting. Theories of diffusion were developed for private firms (Kennedy & Fiss, 2009; Tolbert & Zucker, 1983), which may lose market shares if they are slow to adopt innovations. The present study considers a set of PSOs, each functioning as a regional monopoly, which will survive even if they are inefficient (Kantola & Järvinen, 2012). Thus, we propose that, in regard to PSOs, the loss/gain distinction in the Kennedy and Fiss (2009) framework may be relevant for adopting versus rejecting organizations but not necessarily for early and late adopters.

With regard to organizational fits and misfits (Ansari et al., 2010), we note that adopting regions leaned more to the right and had more experience of another market-inspired control (purchaser–provider splits). Rejecting regions leaned more to the left and were smaller and tended to motivate the rejection of ABF with reference to size, administrative capacity, and number of hospitals. These patterns suggest a relationship between political/cultural and technical fit and adoption in line with what one would expect: ABF is an NPM-inspired control, which should be well aligned with liberal political values, and have less appeal in left-leaning settings (Kastberg & Siverbo, 2007; Lapsley, 2008). The larger size is positively associated with the adoption of management controls and a better administrative capacity (Carvalho et al., 2012; George et al., 2019), and the presence of more than one hospital (or site) is a prerequisite to benefit from the idea of (re)distributing resources between hospitals (or hospital sites) in line with their (reported) production of services (Busse et al., 2011; Jegers et al., 2002).

Our longitudinal approach allowed us to examine the decisions to sustain or abandon the practice, once adopted. All abandoning regions returned to a traditional control, namely, budgeting. Hence, the standard explanation for abandonment—the emergence of a new fashionable control (Abrahamson, 1991)—was irrelevant in our setting. The insight that NPM-inspired controls are not only challenged by the adoption of novel governance and management ideas but also by the return to traditional PA is a contribution to the growing body of post-NPM literature (Hyndman & Liguori, 2016; Klenk & Reiter, 2019; Osborne, 2006).

We identify two motives for abandoning ABF. The first motive relates to technical (in)efficiency, that is, dissatisfaction with the outcomes. This was manifested in two ways in our empirical material: Two regions abandoned ABF as a response to mounting problems of inefficient use of resources, in particular, the price differential between outpatient and inpatient services, which served as a disincentive to move from the inpatient to the outpatient setting even when it would be feasible medically (see also Bureau et al., 2018; Ellegård & Glenngård, 2019; Glenngård & Ellegård, 2018). Two other regions abandoned ABF because it did not result in the increased transparency of the priority setting they had hoped for. The second motive relates to political/cultural misfit. Three regions mentioned a better fit between their organizational culture and context and the values and beliefs inherent in budgeting. Hence, regions that adopted ABF despite a political/cultural misfit (Ansari et al., 2010; Ax & Greve, 2017) chose to abandon the adopted practice rather than to continuously adapt it when they were not satisfied with its outcomes.

Our results support previous research, which suggests that management controls should be regarded as dynamic, subject to change by each adopting organization to fit the specific context (Ax & Bjørnenak, 2005; Bjørnenak & Olson, 1999; Malmi & Ikäheimo, 2003; Modell, 2009). Similar to earlier findings by Kastberg and Siverbo (2007), we observe that regions adopting ABF cannot be viewed as having introduced a homogeneous control practice as an answer to a common challenge. Both the fidelity and extensiveness (Ansari et al., 2010) in the use of ABF varied substantially between regions. In line with Ansari et al. (2010), our data highlight that controls may be regarded as dynamic also within organizations, continuously adapted in response to new circumstances. The propensity to make continuous adaptations seems to be associated with the length of time during which the practice was sustained. The two regions that used ABF for extended time periods without making continuous adaptations (Region 5, 19 years and Region 4, 7 years) retained their initial motives for a long time and therefore had no need to make continuous adaptations. When they had to make such adaptations, they abandoned ABF. Furthermore, the decision motives of regions that sustained the practice for a relatively long time tended to reflect a technical efficiency rather than a social legitimacy logic (Kennedy & Fiss, 2009). By contrast, regions that referred to decision motives closer to a social legitimacy logic tended not to make further adaptations of the model in response to failures to achieve the stated goals. Instead, they abandoned ABF. This finding is perhaps not surprising, as the characteristics inherent in the control under study make it better suited to help achieve economic rather than social gains and that organizations will try to minimize the costs for adaptations (Ansari et al., 2010).

We contribute with a framework explaining the abandonment or sustainment of a management control (Figure 3). Our framework acknowledges the interplay between the decision motive underlying the adoption and the propensity to continuously adapt the control in response to new organizational goals and circumstances. We propose that whenever there is either both technical and political/cultural fit or neither thereof, the type of decision motives (technical

or social) does not matter for the ability to benefit from the control in relation to the motives behind the adoption. With fit (misfit) in both dimensions, the organization is likely (unlikely) to benefit from the control and thus sustain (abandon) it, no matter if it was adopted with reference to technical efficiency or social legitimacy gains. Furthermore, a political/cultural fit may facilitate the mindful initial adaptations (Chandler & Hwang, 2015) necessary to overcome a lack of technical fit, and thus enjoy the expected benefits of the control in relation to the initial motives, regardless of the underlying decision motive. However, the decision motive starts to play a role in the event of political/cultural misfit. In such circumstances, a technical fit may ensure that the control delivers the intended benefits if these are related to technical efficiency but is unlikely to do so if the intended benefits relate to social legitimacy.

Although prevailing technical and/or political/cultural misfits may forebode a future tendency to sustain or abandon the control, we observe that mindful adaptations at the time of adoption break the link between misfits and the likelihood to abandon the control—as long as the organization retains the same goals as at the time of adoption. As new objectives and circumstances arise, things may change. Organizations whose technical and political/cultural fit remains high (or low) are still likely (or unlikely) to make the further adaptations needed to ensure that the control is compatible with the new objectives or circumstances. But now, a political/cultural misfit at the time of adoption is sufficient to predict a low propensity to make further adaptations, and thus a high propensity to abandon the control, regardless of the original decision motive. The intuition is that the motivation to use the control is not strong enough to make it survive, even if the organization is capable of adapting it to the new situation. What happens when circumstances change in settings with a political/cultural fit but a technical misfit is not possible to determine theoretically. In our setting, we observed that a motivation to use ABF was not enough to overcome a lack of capacity to make adaptations that could have made the control sustainable. Specifically, Region 5, where there was a firm political/cultural fit founded in the stable center-right political majority, sustained their use of the control for almost 20 years but was too small to have the administrative capacity to make continuous adaptations of the model when novel decision motives prompting such adaptations emerged.

## 7 | CONCLUDING REMARKS

This study explores the almost three-decade-long journey of activity-based hospital funding, an NPM-inspired control, across and within PSOs. By approaching key informants in all Swedish regional healthcare authorities, we were able to examine not only the decision motives behind the adoption of the control but also the motives behind the rejection and the determinants of its sustained use. Our study contributes to the post-NPM literature (Hyndman & Liguori, 2016; Klenk & Reiter, 2019; Osborne, 2006) by the insight that NPM-inspired controls are challenged not only by novel management ideas but also by the return to traditional PA.

The study of rejecting organizations allows us to contribute to the literature on diffusion of practices (Abrahamson, 1991; Ax & Greve, 2017; Kennedy & Fiss, 2009; Tolbert & Zucker, 1983) by recognizing that the issue interpretation (Kennedy & Fiss, 2009) may differ starkly between adopters and non-adopters. Indeed, in our data, this difference was larger than that between early and late adopters. Additionally, we find that the decision to reject, just like the decision to adopt, can be linked to technical, political, and cultural fit between the organization and the properties of the control (Ansari et al., 2010). This finding corroborates the main body of evidence in this literature, which mostly relies on case studies of adopting organizations.

We develop a framework in which the decision to sustain or abandon a management control initiative is explained by the initial benefits of the control and by the interplay between the decision motive underlying the adoption (Kennedy & Fiss, 2009; Tolbert & Zucker, 1983) and the propensity to continuously adapt it. We conclude that PSOs may benefit from a control even in a situation with misfits, contingent upon a mindful initial adaptation (Chandler & Hwang, 2015) and that a control is sustainable as long as the organization can benefit from it without making significant further adaptations. We further posit that the sustainability of a control in the face of new organizational goals and circumstances depends on the organization's propensity to make continuous adaptations of the control. This propensity is higher in organizations where there is a technical and political/cultural fit between organizational

characteristics and the inherent properties of the control, that is, in organizations with a capability (Ansari et al., 2010), motivation, and commitment (Ansari et al., 2010; Ax & Greve, 2017; Oliver, 1992) to use the management control. Our results also provide some implications for practice: For organizations to benefit from a management control, it has to be adapted, not only initially but also continuously to maintain fit with the local context as it evolves. This implies that small organizations, with limited administrative capacity, may experience difficulties to benefit from a complex control such as ABF.

Our framework captures the entire journey of a management control initiative—from the decision motives for adoption or rejection to the subsequent decision motives for sustaining or abandoning the control. A strength of our empirical setting is that it allowed us to explore decision motives among all organizations in a group of potential adopters. Nonetheless, there are only 21 regions. Further research is needed to examine the applicability of the insights to other contexts and other types of controls. It should also be noted that we rely on civil servants' perceptions of decision motives. Although they have detailed knowledge about the setting, it is possible that other perspectives and interpretations would have emerged if we have interviewed the politicians who took the formal decision about the funding model. Furthermore, we collected data retrospectively. Our approach can be defended on grounds of the relatively strong political stability and the ease with which we were able to reach and interview civil servants who had worked in relevant positions at the time of implementation. Yet, an ideal setting for future research would be to employ a prospective longitudinal approach, to monitor decision motives as they unfold.

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## CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

## DATA AVAILABILITY STATEMENT

The registry data are available from the NBHW ([www.socialstyrelsen.se](http://www.socialstyrelsen.se)) upon request. Notes from interviews are available from the authors upon reasonable request.

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## NOTES

<sup>1</sup> Once adopted, the control may over time become institutionalized, that is, turned into a constraint on organizational behavior that is beyond questioning (Meyer & Rowan, 1977). As almost all of our study regions abandoned the control within a rather short period, their use of ABF is better viewed as what Aksom (2021) calls a highly diffused but non-institutionalized control practice or what Abrahamson (1991) calls a fashion or a fad. Hence, although our theoretical framing is inspired by institutional theory, the purpose is not to study the institutionalization or deinstitutionalization (Oliver 1992) of a control.

<sup>2</sup> Four regions experimented with ABF based on other pricing systems during the 1990s (Anell 1996; Gerdttham et al 1999; Kastberg & Siverbo 2007). One of these regions was later merged with a larger region that adopted DRG-based ABF, while another region used DRG-based ABF in 2007–2008.

<sup>3</sup>Questions 5–7 captured other uses of the DRG system than ABF, that is, to what extent the region used the classification system to describe activities or monitor providers, not explicitly analyzed in the present article.

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