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**The Gender Subtext of New Public Management Based Work Practices in Swedish  
Health Care**

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## **ABSTRACT**

**Purpose** – We propose a theoretical framework for researching gender equality implications of Clinical Microsystems, a New Public Management based model for multi-professional collaboration and improvement of health care delivery.

**Design/methodology/approach** – The article draws on literature from gender in organizations, new public management, multi-professional collaboration and organizational control to critically analyze the Clinical Microsystem model.

**Findings** – While on the surface an egalitarian and consensus based model, it nevertheless risks reinforcing a gendered hierarchical order. The explicit emphasis on social competencies, on being collaborative and amenable to change risks, paradoxically, disfavoring women. A major reason is that control becomes more opaque, which favors those already in power.

**Practical implications** – The article calls for researchers as well as practitioners to incorporate concerns of equality in the work place when introducing new work practices in health care. For research, we propose a useful theoretical framework for empirical research. For practice, the article calls for more transparent conditions for multi-professional collaboration, such as formalized merit and advancement systems, precisely formulated performance expectations and selection of team members based strictly on formal merits.

**Originality/value** – A gender analysis of a seemingly anti-hierarchical management model is an original contribution, adding to the literature on Clinical Microsystem in particular but also to critical studies on New Public Management. Moreover, it has a valuable practical contribution in suggesting ways of avoiding the reproduction of gender inequalities otherwise implied in the model.

**Keywords** Clinical Microsystem, Gender equality, Health care, Multi-professional collaboration, New Public Management

**Paper type** Conceptual paper

## **Introduction**

New Public Management practices inspired by industry and business are implemented in Sweden and elsewhere (Hood, 1995, Leonard et al., 2004). The particular model discussed here, Clinical Microsystems, promises to increase efficiency and quality of health care delivery by focusing on enhanced inter-professional collaboration. It stresses the staff's responsibility for ongoing quality improvement in collaborative multi-professional teams, promising flattened hierarchies and decision making close to the professionals. However, Swedish health care also has well documented social inequalities, such as a gendered hierarchy, gendered professions, and stereotypical gender expectations, encompassed by both staff and patients (Öhman, 2004, Smirthwaite, 2007), and a culture advocating homogeneity (Lindgren, 1999). While inequalities in health care delivery in reference to patients are well researched, less attention is given to issues of inequality amongst staff, and there is a paucity of research on equality implications of new management models in health care (Standing, 1997, 2000). The current emphasis on new models for inter-professional collaboration makes this an urgent topic. This article draws on literature from research on gender structures in health care, new public management, multi-professional collaboration, and organizational control to critically analyze the Clinical Microsystem model as presented by its proponents. We begin by describing the introduction of New Public Management in Swedish health care, detailing the Clinical Microsystems model and the new, innovative, change-oriented professional this model calls for. Putting this model into its context, a gendered professional work culture, we turn to management control theory to discuss the potential consequences for gender equality, and offer a theoretical framework on which to base future empirical research.

## **New Public Management in Swedish health care**

Swedish health care used to be a state owned monopoly, organized as a rule-based bureaucracy with a strict hierarchy and chain of command. The professions, particularly physicians, had unquestioned authority. The last three decades have seen a steady transformation of Swedish health care organization, with the gradual introduction of New Public Management models (Agevall, 2005, Björk et al., 2011, Dahlgren, 2010, Martinussen and Magnussen, 2009). These are argued as a necessary response to problems of efficiency and quality in health care delivery, due to increased longevity, improved medical remedies, and monetary limitations (Bergmark, 2008, Magnussen et al., 2009, Williams et al., 2007). More efficient health care delivery cannot be accomplished by medicine alone; there is a call

for innovative work practices (Berwick et al., 2008, Calltorp et al., 2006, Sweeney and Kernick, 2001).

New Public Management (NPM) introduces management models from the private sector in public sector management. It questions bureaucracy for being inflexible and inefficient, and says that efficiency will increase if citizens can make choices on a market, as customers. This will force service providers to compete with each other and improve their services (Carter, 2000, Hood, 1991, Leicht et al., 2009). Consequently, parts of primary care, pharmacies, elder care and also hospitals have been privatized in Sweden, but they are still publicly funded and (almost) free of charge to the citizen. Large public organizations such as hospitals are divided into smaller cost centers and systems of internal charging are introduced. Privately and publicly owned units compete on equal terms. If this is to work, citizens must be able to make informed choices. A national tracking system for healthcare results with over 170 performance indicators, “open comparisons”<sup>i</sup> has therefore been made mandatory for health care providers in Sweden. The results are available to anyone in a document of 300 pages on the web (Swedish Association of Local Authorities and Regions and The National Board of Health and Welfare, 2011).

If the average patient consults this information before choosing a caregiver is uncertain. More certain are the organizational results of the reform. The professions have lost power and influence to management. As the system has replaced rule-based management with management by objectives it has put more responsibility on local unit management, but at the same time vested more power with central management. Increased measurement and transparency also enables increased disciplinary power (Foucault, 1995).

### **Clinical Microsystems**

NPM also prescribes decentralized authority and the encouragement of participative management (Du Gay, 2000). Organizations are flattened and slimmed and more responsibility for daily management and for product or service development is given to the lower echelons, often in the name of “empowerment” (Powers, 2003). New work methods inspired by methods from private manufacturing industry, such as Total Quality Management (Deming, 1986) and Lean Production (Womack et al., 1990), are introduced. These methods are primarily efficiency and rationalization driven, focusing on using fewer staff, less space, lower inventories, a smaller number of suppliers, and involve extensive measurement and

calculation of errors and variations, as well as documentation and standardization of procedures and methods (Abrahamsson and Johansson, 2008). The Clinical Microsystem represents a younger adaptation of these models and was introduced by US scholars in the 1990s (Nelson et al., 2007a). Since then it has been implemented in several Swedish public health care organizations as well as in US and UK settings (Ferlie and Shortell, 2001, Williams et al., 2009, Andreasson and Winge, 2009).

A Clinical Microsystem is comprised of the entire group of health care professionals that meets a patient. Patients and their relatives are considered integral parts of the microsystem. The central premise is that improvement of care emanates from better functioning microsystems engaged in constant quality development through performance measurements (Agevall, 2005, Björk et al., 2011). Clinical Microsystems are assumed to provide (1) greater standardization of common activities and customization of care to individual patients, (2) better use and analysis of information to support daily work, (3) consistent, measured improvement in performance, (4) extensive cooperation and teamwork within the microsystem, and (5) an opportunity for dissemination of best practices across Clinical Microsystems within their larger organizations (Donaldson and Mohr, 2001). The model holds thoughts of bottom-up processes, empowerment, multi-professional cooperation, and consensus. It focuses informal and social competences of staff, stressing change of attitudes, approaches, and measuring processes, and staff is evaluated on being collaborative, flexible and, not least, innovative (Berwick et al., 2008, Kvarnström, 2011). In practice, Clinical Microsystems have been implemented as projects – the personnel at a clinic has been organized in teams, and time, and sometimes a facilitator, has been provided for meetings and discussion and improvement of practices (Williams et al., 2007, Nelson et al., 2007b).

### **The new professional: change-oriented, co-operative and socially competent**

Whereas the models from industry that Clinical Microsystem draws on, such as TQM and Lean Production (Nelson et al., 2007a) explicitly focus rationalizations and cost control, Clinical Microsystem is principally argued in terms of quality improvement (Ferlie and Shortell, 2001). Quality improvement work, in which collaboration is emphasized, has been introduced and gained importance as an organizational philosophy in health care over the last fifteen years (Batalden and Davidoff, 2007). This philosophy contains the assumption, as does Clinical Microsystem, that collaboration is a more effective means of achieving a goal than multiple individual efforts (McLaughlin and Kaluzny, 2005). Each member of staff,

irrespective of profession, is held responsible for the ongoing work on quality improvement, which entails that each staff member must embrace collaboration with other staff (and other Clinical Microsystems) and must contribute to the development of effective inter-professional and multidisciplinary teams. In Clinical Microsystems, an individual's performance is judged according to overall patient health outcomes, not merely according to his/her individual clinical efforts – individual responsibility thus extends beyond individual performance. The formal professional knowledge gained through an individual's education and experience is of course still paramount, but not enough: the behavior and personal characteristics of the individual professional becomes increasingly significant (Abernethy and Stoelwinder, 1995). An attitude or disposition toward change and cooperation is valued as contributing to good and effective development and improvement in the organization. Consequently, organizations increase their investments in various training and education programs concerning teamwork and change readiness (Abrahamsson and Johansson, 2008, Frush et al., 2012, O'Leary et al., 2011). As du Gay (2000) argues, NPM is not only a new way of managing the public sector, but it also entails the production of a new subjectivity, the “enterprising self”.

The few empirical studies that exist on Clinical Microsystems are positive or mixed. Studies report benefits such as improved communication, motivation and morale, more involvement, greater awareness of one's own role in the service delivery, a more improvement-oriented culture and a greater capacity to absorb and manage externally imposed change (Nelson et al., 2007a, Nelson et al., 2010, Williams et al., 2007, Williams et al., 2009); but also drawbacks such as the frustration of identifying problems that prove to be insoluble, the time and capacity taken up in the implementation (Williams et al., 2007) and a general confusion about what the model entails (Jukkala et al., 2011). These studies are made from a management perspective, however, and say nothing about the consequences for personnel of different social positions. Positions such as gender, ethnicity, age, class or educational background, and resulting power differentials is not an issue – it is completely overlooked. Whereas organizational interventions in respect to gender are usually argued either as a moral case – gender equity for fairness, or as a business case – gender equity for resource utilization, efficiency/quality or increased competitiveness (Bagilhole, 2009, Standing, 2000), we argue that in Clinical Microsystems, there is no such case at all. There is a business/quality case, yes, but it does not address gender. Furthering our discussion, we describe the situation in Swedish health care next, drawing on available statistics and research. As statistics about health care staff is only available for gender, we limit our discussion to this position, but

believe that our resulting theoretical propositions are transferrable to other social positions as well.

### **The context: gendered professional work cultures**

Historically, gender patterns in Swedish health care were unambiguous. Physicians were men and in power, nurses and assistant nurses were women, and subordinated. Administrative and managerial personnel had a supportive role. With the advent of NPM, healthcare organization in Sweden has become a mix between the traditional hierarchical top-down organization and the more modern organization that emphasizes cooperation and shared values (Öhman, 2004). Even if the professions have lost some power to management, health care is still characterized by strong professional cultures that influence how the organization's members make work-related decisions. Physicians, nurses, assistant nurses, physiotherapists et cetera, constitute various cultures and sub-groups with their own sense of group affiliation (Fritzén, 1998, Kvarnström, 2011). Common values within each of these professions have developed over a long period of time and helped create stability in the organization. Common ways of interpreting experiences arise, and daily activities become routine and taken-for-granted. The culture is thus a stable collection of specific inherited assumptions, beliefs, values and opinions which together form the point of departure for daily activities. These assumptions become institutionalized as they are constantly used to solve problems and work in practice (Berger and Luckmann, 1966, Kvarnström, 2008).

Besides making up strong sub-cultures, the professions are also segregated by gender. Men still dominate in positions of power and women in subordinate positions in health care organizations not only in Sweden, but all over the world<sup>ii</sup>. As leadership is strongly male gendered (Ahl, 2006, Ahl, 2007, Burriss, 1996, Eagly and Karau, 2002) it is not surprising that people in positions of influence, such as physicians, are expected to be men. Employment figures for the County Councils in Sweden reveal that the most common job for men is indeed physician and for women, nurse, and the so called “glass ceiling” alternatively “sticky floor” is clearly present (Bagilhole, 2009, Morrison et al., 1994). The bottom of the organizational hierarchy is dominated by women, and the top by men. For instance, the total number of assistant nurses employed by the Swedish County Councils is 31,795, of which 30,341 are women and only 1,454 men. Higher up the hierarchical ladder, the numbers change dramatically. Even though the County Councils employ four times as many women (201,244 women versus 47,122 men), and in spite of a roughly equal gender distribution at Swedish



medical schools, men still dominate among physicians (14,943 men versus 11,404 women) (Lindquist, 2005). This has historical reasons, but whereas more and more women become physicians, men rarely enter nursing so the gender order remains.

### **Clinical microsystems and gender equality: opportunity or constraint?**

From a feminist standpoint perspective, Clinical Microsystem appears to be good news. Essentialist and widely held understandings of women as having good relational and communicative skills, and being cooperative and consensus oriented appear to fit nicely with the kind of personal traits favored by the Clinical Microsystem model. The last two decades of organizational change in health care have aimed to gradually dissolve separate group cultures and replace them with a co-worker culture that strives to include all subgroups of health care staff (Lindgren, 1999, Wall, 2009). Consensus, rather than difference, is stressed and diversity is overlooked (Wall, 2009). In this transition, Clinical Microsystem and its accompanying philosophy of quality improvement are considered important tools as they embody an aspiration for increased collaboration between health care staff. At first glance, the model therefore promises both improved health care delivery *and* a more egalitarian work place.

Taking a Foucauldian feminist approach, which regards ideas of women as relational and caring as social constructions of gender with implications for the gender/power order (Gherardi, 2003, Weedon, 1999), there is reason for concern. Previous research in this tradition has demonstrated how NPM privileges new forms of masculinity within public administration – competitive, single-minded and work-aholic – and how this has reinforced rather than challenged the gender substructure of the organization. Women either took up the challenge, which came at a high price as family is in most cases still the woman's responsibility, or they picked up the pieces at work and resorted to feminine gendered task of less status (Davies and Thomas, 2002, Thomas and Davies, 2002). A Swedish study of municipal management demonstrated similar results for the women dominated social services – they were made to work harder – but contradictory results for male dominated technical management. The men had more negotiating power and were able to resist the discourse of NPM and maintain bureaucracy (Björk et al., 2011, Kahn, 1999). Worts (2007) study of Canadian front line services also showed how women accommodated the changes whereas men resisted.

Clinical Microsystems is a fairly new concept, and there is, to our knowledge, no empirical research on how it affects gender patterns. From a theoretical perspective, there is concern, that aspects intrinsic to the model do not adequately account for the institutionalized gender order in health care and may therefore risk reproducing it. We discuss this below using theories on organizational control as an analytical vehicle.

### **New Public Management: changing forms of organizational control**

To ensure that an organization meets its goals it uses a variety of control mechanisms. In a study of organizational consequences of new information technology in work processes, Orlikowski (1991) uses a framework built on management theory on organizational control<sup>iii</sup>, which we find fruitful and adopt for the purpose of analyzing gender effects of Clinical Microsystems. Orlikowski emphasizes that control mechanism are both enabling and constraining. They facilitate the coordinated action of individuals, but they also restrict the manner and outcomes of individuals' actions. Drawing on Pennings and Woiceshyn (1989), Orlikowski distinguishes between internal and external control. Internal control may be either *personal*, i.e. direct supervision, or *systemic*, which is indirect and impersonal and built into an organizations' technology, social structure, and culture. External control has its roots outside the organization. Relevant for our case is *professional control*. Health care is reliant on professionals who have complex rules "built into them" from their professional training.

The introduction of NPM and Clinical Microsystems has changed the configuration of these forms of control in health care. Traditionally, health care specialists have been accustomed to high levels of autonomy in their work, conferred by their professional training (Abernethy and Stoelwinder, 1995, Jespersen and Wreda, 2009). In addition to professional control, health care professionals are also accustomed to personal control. Within the bounds of one's profession, elder colleagues often direct younger, and physicians control nurses (Fritzén, 1998). Even if based on hierarchy and seniority, personal control is open, clear, well-defined and transparent for the involved parties. Professional control and transparent personal control has thus provided health care staff with a great deal of autonomy.

As NPM and Clinical Microsystems not only focus the end product but also work processes, this has led to increased systemic control. Systemic control vested in information technology is increasingly used to measure and monitor what health care professionals do. Measurements are readily available, not only to management but also to the general public. Increased

surveillance of work processes has led to decreased autonomy for the staff – the role of personal as well as professional control has diminished and administration has seen its power increase at the expense of the clinical staff (Abernethy and Stoelwinder, 1995, Abrahamsson and Johansson, 2008). In most instances, professionals are accountable for producing these measures themselves, and thus co-create this form of control.

Systemic control vested in social structure is embedded in the organization's rules, policies and procedures and in well-defined job descriptions, career ladders and incentive schemes. A hallmark of bureaucracy is clear and transparent standards with explicit job requirements, whereas NPM argues for a more flexible approach. The emphasis on teamwork, empowerment, and informal and social competencies in Clinical Microsystems may give the illusion of a flat organization and a sense that influence is widely spread when, in fact, influence becomes strictly conditional; in order to exercise influence, an individual must behave in a prescribed way and display the appropriate attitudes (Powers, 2003), such as being collaborative and flexible.

In systemic control through culture, employee's shared norms and values shape behavior, order perception and influence attitudes. Clinical Microsystems is an attempt to create a co-worker culture with an emphasis on inter-professional collaboration and consensus. These norms and values may create a culture of blindness in which differences and conflicts between different groups of professionals are suppressed or made invisible (Kellogg et al., 2006).

As Orlikowski observes, systemic control can be seen as an example of Foucault's disciplinary power in that control is exercised indirectly and does not emanate directly or physically from individuals. Disciplinary power is less visible, and concealed behind the seeming neutrality of knowledge, technology, or morality. Paradoxically, writes Orlikowski (1991:12), "as disciplinary power becomes less visible, its objects – individuals and their behavior – become more visible". Individuals are not a uniform group, however, and the changing forms of control may have different effects for individuals who are differently situated. Next, we extend the analysis to gender.

### **Gender equality and new forms of control**

The expansion of systemic control through Clinical Microsystems may have some unintended side effects. While seemingly anti-hierarchical, collaboration and consensus oriented, when applied in an organization characterized by a gendered hierarchy it risks reproducing the same (Kvande, 2007).

There are two major concerns with the model. The first is the increase in systemic control at the expense of personal and professional control. Decreased professional control makes it more difficult to influence one's own work. Decreased personal control makes it harder to know who or what actually manages, and therefore also more difficult to influence one's own situation. Control becomes opaque and difficult to localize which diminishes the staff's autonomy. One important aspect of systemic control is the stress on inter-professional cooperation. With strong gendered professional cultures, achieving cooperation between different units and different categories of staff in a health care organization presents a double challenge. The organizational structure made up of strong professional cultures creates invisible walls and territorial thinking (Kvarnström, 2008, Reeves et al., 2009), and asymmetric, gendered relations between different categories of staff tend to influence staff perspectives on cooperation (Östergren and Sahlin-Andersson, 1998). A survey among 2050 nurses and 551 physicians on cooperation and trust in professional competence (Krogstad et al., 2004) reflecting the gendered hierarchy illustrates this point. Both nurses and physicians saw the latter as highly competent, but many physicians were uncertain regarding the nurses' competence. An interesting paradox was established: Even though physicians – the traditionally dominant group – rated the nurses' competence lower than they rated their own, they were more satisfied with cooperation than were nurses. This study questions, as does Acker (2006), the taken-for-granted knowledge that it is the dominant party who opposes cooperation in fear of losing responsibility and status. On the contrary, cooperation may be experienced as less problematic by the dominant partner. Nurses may oppose cooperation due to “underdog dissatisfaction” – physicians are praised for good work more often than nurses, by members of their own profession as well as by nurses, while nurses mainly receive appreciation from other nurses (Krogstad et al., 2004) and are still considered – by themselves and others – as mere medical assistants to physicians (Ekstrand, 2010). Inter-professional cooperation is in this perspective cooperation on unequal terms, and may actually help strengthen entrenched hierarchical gender patterns.

The other major concern is the emphasis on personal characteristics such as social competence and readiness for change, which comes at the expense of formal merits derived from professional education and experience. Such characteristics are more difficult to assess in an objective and transparent manner, and experiences so far show that the change favors men. As noted earlier, with common understandings of “how women are”, promoting personal traits such as being collaborative, flexible and, not least, innovative in one’s professional practice in addition to strictly practical and clinical tasks should be positive news, but as organization scholars such as Acker (1992) demonstrate, in order to gain equality in terms of opportunities and responsibility, women need to function in a “traditional” masculine way, such as being aggressive, competitive and self-promoting, and a consensus culture does not promote this. Other researchers (Barker, 1993) suggest that team-organized work tends to stabilize norms rather than challenge them, and therefore, as Acker (2006) points out, may not reduce entrenched gender inequalities at all. When job descriptions are broadened to include behavioral and social competencies, this tends to benefit the group in power (Krogstad et al., 2004). When formal rules and regulations are replaced by informal ones, and when organizations are flattened and made less bureaucratic, this tends to disfavor women (Björk et al., 2011, Kahn, 1999; Worts, 2007).

Both official and informal meetings in which strategies and policies of organizations are discussed tend to be spaces for homosocial reproduction (Holgersson, 2012, Kanter, 1977), where male bonding and solidarity develops and is affirmed. The exclusion of women from these groups diminishes their chances of gaining social and cultural control. As prior work indicates, this contributes to the reproduction of the status quo. Eräsari’s (2002) study of NPM in Finland showed that whereas the bureaucracy promoted women on formal merit, after NPM more men were promoted, on the less transparent basis of “social competence”. In Britain, when an in effect female-only career ladder in nursing was opened to men, they took the “glass elevator” and soon occupied half of management positions in spite of comprising only ten per cent of the work force (cited in Standing, 2000). Also in Britain, when decision-making was decentralized to increase efficiency in the National Health Service, heterogeneity became a problem. This served to strengthen existing discriminatory patterns and practices, in this case in regard to ethnicity (Carter, 2000). NPM allowed those responsible for recruitment the organizational space to discriminate, concludes Carter.

## **Concluding discussion**

In this article, we have used research on gender in organizations combined with a theoretical framework on management control to discuss gender implications of NPM and Clinical Microsystems. We conclude that the increase of systemic control at the expense of personal and professional control risks reproducing the gendered hierarchy in health care. When systemic control increases, there is a risk that what is left of the declining personal control goes to those who formally have and informally get the best conditions to exercise it. When professional authority is downplayed, this cannot be used as a resource to challenge stereotyped gender expectations.

We further propose that the stress on being collaborative and amenable to change prevents individuals from challenging current social orders. Multi-professional collaboration may increase clinical efficiency and customer satisfaction but it may also increase dissatisfaction amongst professions lower down the hierarchical ladder who have less power and are seen as less collaborative, in this case nurses and assistant nurses. Thus, innovation in health care delivery such as Clinical Microsystems may change the delivery of care, but holds no clear promise of challenging gender inequalities in health care.

Such conclusions call for action. For research, we offer a useful framework for empirical research about NPM in health care in general and Clinical Microsystems in particular. Our model suggest mapping changes in forms of control related to the introduction of new management models, and studying the effects for gender equality of these changes. Effects may be studied either quantitatively through for example promotion or salary statistics, changes in the gender distribution of the professions, statistics on who is given training opportunities, and so on (Standing, 2000) or qualitatively through interviews and/or participant observations, studying gendering processes and gendered reasoning (see for example Davies and Thomas 2002), or both. The framework may also be extended for studies of other social positions (see e.g. Carter, 2000 for a study on ethnic discrimination in health services).

For practice, we call for making the conditions for multi-professional collaboration more transparent. Practical solutions might be a more formalized merit and advancement system, performance expectations that are formulated in a more precise manner, and building collaborative teams strictly on formal merits. The combination of transparency and

meritocracy increases opportunities for equality in the workplace according to Castilla (2008). Du Gay (2000) points out that bureaucracy may not be the most efficient system, but it may be essential to ensure democratic values in organizations. However, we do not suggest uncritically rolling back to former models, as the new models are there for a reason – there is indeed a need to increase both efficiency and quality of care delivery. But there is also a need to incorporate concerns for gender equality in the work place when evaluating and implementing such models, which so far has been a neglected area. In essence, there is a need to incorporate gender mainstreaming in management reform in health care.

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<sup>i</sup> [http://www.skl.se/vi\\_arbetar\\_med/oppnajokforelser/halso-\\_och\\_sjukvard\\_2/compare](http://www.skl.se/vi_arbetar_med/oppnajokforelser/halso-_och_sjukvard_2/compare)

<sup>ii</sup> The World Health Organization regularly publishes gender segregated employment statistics, see [www.who.int](http://www.who.int).

<sup>iii</sup> Orlikowski draws on key theorists in organization and management control, such as Pennings and Woiceshynm, Boland, Giddens, Storey, Mintzberg, Ouchi Knights & Willmott, and Starbuck, and combines this with critical theorists such as for example Foucault. See Orlikowski (1991) for full details.