The co-optation of managerialism: Professionals’ responses to accountability pressures

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Abstract

The struggle between bureaucracy and professionalism has been described repeatedly during the last 50 years. Their opposing logics are at the heart of this struggle. Bureaucracy focuses on administrative hierarchies of formal authority, subordination and control, while professionalism focuses on professional autonomy. Since professionals joined organizations, their professional autonomy has decreased while bureaucracy emerged as the more powerful force, especially when administrators renamed themselves as managers. Managerialism is both evasive and direct in its attempts to control professionalism. This is especially evident in public healthcare in the everyday work of the most powerful of the medical professionals – the physician.

Theory provides two archetypical explanations of the outcomes of these control attempts: managerialism will have no influence on professional work (e.g., decoupling) or managerialism will intervene in professional work imposing bureaucratic control (e.g., colonization, resistance). These two explanations mainly describe how one of these conflicting logics “triumphs” over the other, but they fail to describe the cooperative or interactive efforts. In this paper we focus on such an interactive order and how different techniques influence the negotiated order that emerges.

One technique that we especially highlight has received limited attention in organizational research: co-optation. Co-optation means absorbing new elements as a means of averting threats to stability or existence, and where the absorbing part could be an organization, or, as in our case, professionals. Since co-optation means real influence for the co-opted party, the strategy tends to lead to unintended consequences where both parties are influenced in unforeseen ways.

This paper illustrates co-optation processes through a qualitative study of outcare units in child and adolescent psychiatric care (CAP) in Sweden. These units are organized in multi-professional teams including psychiatrist, psychologists, social welfare counsellors and nurses, and are led by a unit manager. The study shows that professionals co-opt managerial logics and managerial techniques that drive their professional interests. Psychiatrists co-opt budget and resource arguments by avoiding patients who are high-risk in terms of medical failure and by enabling a strict focus on psychiatric patients and refinements in patient...
treatments. Furthermore, the co-optation of organizational, formal routines and rules (in the name of evidence-based medicine) for treatment means a risk transfer from the professional to the organization. Co-optation can explain unintended consequences of managerial reforms since it regards professionals as active, interpreting, strategic actors who use reforms in their interests. Thereby co-optation can describe how a negotiated order between managerialism and professionalism appears. A negotiated order may mean nothing happens (de-coupling) or that professional values are destroyed by managerialism (colonization). It is possible to view co-optation practices as a form of resistance, but it is a very subtle resistance. Professionals do not need to openly resist the administrative reforms since they co-opt them.

**Introduction**

The struggle between bureaucracy and professionalism has been described repeatedly during the last 50 years. Their opposing logics are at the heart of this struggle. Bureaucracy focuses on administrative hierarchies of formal authority, subordination and control, while professionalism focuses on professional autonomy. Since professionals joined organizations, their professional autonomy has decreased while bureaucracy emerged as the more powerful force, especially when administrators renamed themselves as managers (Glouberman & Mintzberg, 2001). Managerialism is both evasive and direct in its attempts to control professionalism. This is especially evident in public healthcare in the every day work of the most powerful of the medical professionals – the physician.

Theory provides two archetypical explanations of the outcomes of these control attempts: managerialism will exert no influence on professional work or managerialism will intervene in professional work imposing bureaucratic control. Examples of the first explanation are decoupling (Orton & Weick, 1990; Powell & DiMaggio, 1991) and organizational hypocrisy (Brunsson, 1989). According to this theoretical explanation, managerial practices that control professionals are a façade produced for external constituents, but the control has no restricting effects on the professional autonomy at the core of the organization. Examples of the second explanation are colonization and resistance in various forms (e.g., Bolton, 2004; Bolton & Houlihan, 2005; Thomas & Davies, 2005; Spicer & Böhm 2007; Spicer & Fleming, 2007). According to this theoretical explanation, bureaucracy manages to intervene in the core of the professional practice and impose bureaucratic control on the professionals that is detrimental to their autonomy. Professionals are then described as colonized by a new policy structure that they dislike. Concurrently, the autonomy of the professionals appears to steadily diminish as various control measures are spread (e.g., Freidson, 2001/2006; Timmermans, 2008).

These explanations have in common that they seem to regard the meeting between managerialism and professionalism as a zero sum power game, where the amount one side gains corresponds to the same amount the other side loses. Descriptions like competition clashes and colonization support this impression. Both categories of explanations describe reasons for the difficulties in implementing managerial reforms. However, despite all reports of such difficulties, several researchers have found that although single reforms are seldom successful, according to short-term evaluations, after thirty years of unsuccessful implementation of managerial reforms they have now changed practice and are taken for
granted. In short, they have become institutionalized (Dunleavy et al., 2006; Christensen & Laegreid, 2007; Hasselbladh et al., 2008). It is well recognized that healthcare organizations today are closely involved with planning, cost accounting, performance measurement, customer satisfaction, as well as with management hierarchy, mission and values. However, it seems research is missing something. Otherwise, why have all these “failed” managerial reforms produced this major change in public organizations?

We claim that these two theoretical explanations mainly describe how one of these conflicting logics “triumphs” over the other but fail to describe cooperative or interactive efforts. Professionals and managers can use strategies other than decoupling or colonization that can result in reforms intended to be fulfilled to some extent with some degree of professional autonomy. In this paper we focus on such an interactive order and the different techniques that influence the negotiated order that emerges. Our aim is to illustrate a possible middle way of understanding the professionals’ responses to the managerial logic. One technique that we especially highlight has received limited attention in organizational research: co-optation. Co-optation means absorbing new elements as a means of averting threats to stability or the status quo where the absorbing part could be an organization, or, as in our case, the professionals. Since co-optation means real influence for the co-opted party, the strategy tends to lead to unintended consequences where both parties are influenced in unforeseen ways.

This paper analyses episodes of managerial and professional strategies with different logics in the practice of child and adolescent psychiatric outcare (CAP) in Sweden. There have been significant changes in the CAP units in the last ten years that have led to increasing professionalization with new professions, such as physician and nurses, on the teams. This has coincided with an increasing managerial logic manifesting itself in increased accountability pressures. Thus, this setting provides fertile ground for studying professional and managerial responses to different logics because it contains multiple professions working in a context where a new managerial logic (NPM) has been implemented. This logic includes adaptation to a way of organizing that prioritizes efficiency and marketized or market-like arrangements (Christensen and Lagreid, 2011; Hood, 1991; Hasselbladh et al., 2008). Thus, based on the CAP case data, our study shows how professionals and managers respond and relate to two particularly common institutional logics in healthcare settings: that is, the “managerial” logic based on financial calculations and the “professional” healthcare logic based on medical and other healthcare professional norms (Choi et al., 2011; Kitchener, 2002; Reay & Hinings, 2009; Scott et al. 2000).

The paper is structured as follows: First, we describe the different logics of professionalism and managerialism. Then we continue with a description of how a possible mid-way of the two can occur using the concept of negotiated order and co-optation. This is followed by the case that describes how professionals at child and adolescence psychiatry respond to managerialistic control attempts in form of an increased accountability pressure. In the following analysis and conclusion we describe how co-optation processes can explain outcomes that mean transformation of the two logics of professionalism and managerialism.
The professional and the managerial logics of healthcare

There is a tradition dating from the Middle Ages that professionals, such as physicians and attorneys, have a position similar to that of entrepreneurs or sole proprietors. With the emergence of large corporations in the 20th century, increasingly corporations have employed these professionals. Thus, the presence of professionals in the bureaucratic organization is not a new phenomenon. However, in recent decades managerial approaches and practices, in their various forms, have been introduced with the aim of improving efficiency and customer orientation (Hood, 1994). Professionals, who formerly held semi-autonomous positions in organizations, have found themselves under the control/influence of managerialism. This situation has increased the complexity of healthcare where different and often competing logics characterize the work (e.g., Glouberman & Mintzberg, 2001; Liff & Andersson, 2013). Even with several different divisions of these logics, a central theme among them is usually the clash between professionalism and managerialism (Scott, 2000).

Professionalism

The pre-NPM era, in which professionalism was the logic, was characterized by the professions’ indirect control of organizations. Society views the professional as having achieved a guaranteed competence through required education and a certain position with specified duties and activities. The basis for the guarantee of quality is the trust in the professionals’ competence and judgement. The professions are mainly accountable to themselves and to the professional organizations rather than to the organizations that employ them. The claim is that this accountability implies accountability to patients and to society at large since the service ideal means that the professionals work in the best interests of patients (Liff & Andersson, 2011). In that sense, lateral accountability was the main form of accountability in the pre-NPM era. Lateral accountability is a form of socializing accountability where interdependence between the self and others is mainly created and fostered by frequent face-to-face contact with people (Roberts, 2001). An example is the socialization into a professional culture. Lateral accountability differs from hierarchical accountability that is mainly based upon administrative systems and may individualize accountability because managers and employees are required to report performance, and so on.

The service ideal is the pivot around which the moral claim to professional status revolves (Wilensky, 1964). Society demands that the professions uphold this ideal as a condition of the professions’ independent right to act for, treat, represent and teach others. The professional logic behind the service ideal in medicine is consequently not based on “doing what the patients wants” or on satisfying them – what is today referred to as customer orientation in both the private and public sectors [cf. customised care in healthcare (Bolton, 2002; Davies & Thomas, 2002; Bolton & Houlihan, 2005)]. Instead, the professional logic of the service ideal in medicine derives from society’s trust in the medical professionals’ code of conduct that requires professionals to act in the best of interests of patients. Therefore, in following the
service ideal, professional judgement is central in healthcare. Moreover, accountability is to the profession rather than to the patient or to the organization.

There are elements of self-interest given this interpretation of the service ideal as applied to the professions (Larson, 1977). A profession may assert control by using its hierarchic and bureaucratic structure to exert *professional dominance*. Such an assertive act implies that a profession alone knows what is best for its clients or patients and therefore acts unilaterally to provide treatment, advice, and so on. This may create difficulties in situations that require multi-professional collaboration, such as in MPTs (Liff & Andersson, 2011). A corollary of professional dominance is the professions’ desire for self-control, *discretionary power*, separated from managerial control (e.g., Larson, 1977; Abbott, 1988; Ackroyd, 1996; Freidson, 1970/2007). This desire creates an almost inevitable conflict between managers and the professionals when greater managerial control is asserted (Parsons, 1954). Professionals require such discretionary power if they are to make qualitative judgements based on their professional competence; they are disinclined to tolerate interference in this process.

According to many researchers, however, there are dangers associated with too much professional discretionary power. Timmermans (2008), for example, argues that an effective screening of a profession from competition, third party influence and government oversight inhibits that profession’s scientific and organizational development. It is also argued that a high degree of discretionary power in operational decision-making may lead to large variations in the way professional practices are conducted. These variations may call into question the trustworthiness of the scientific reasoning that the professions rely on. Therefore, to persuade the general public and various influential interests to trust the professions, authoritative representatives from the professions may demand greater uniformity among their different practices. However, trust is not necessarily created by the persuasive arguments for actions. Freidson (1970/2007:121) concludes: ‘The only evidence required is of being a bona fide expert’. Furthermore, large variations in practices may make it difficult to implement the policy objectives that governmental authorities expect (Rothstein, 2006). Moreover, large variations in practices may also compromise the legitimacy of the professions if they fail to recognize the importance of the bureaucracy’s resource management demands.

Freidson (2001) argues that the ambition of professionalism is to create a specific logic for the organization and control of work that reflects the following quality standards: expertise, service, autonomy, worthwhile knowledge, and a commitment to trusting relationships. Professionalism in an organization means that clients/customers/patients can expect to receive services that follow a standardized and approved practice. To understand professionalism’s demands on how professionals should work in an organization, it is necessary to accept that professional knowledge and ways of working must be standardized in some degree. Yet professionals must also be given leeway to decide how to handle difficult tasks. As Freidson (2001:155) explains, the ways of working must be ‘sufficiently codified that standards of competent performance can be established, though not so standardized that discretionary judgement appears to be unnecessary’.
Managerialism
In the NPM era, a managerial logic of control developed that tried to address the problems resulting from the use of the professional logic of the preceding era. The professions’ insistence on determining their ways of working had created a control problem based on a resource perspective (Ferlie et al., 1996; Friedson, 2001). Professionals were not accountable for resource efficiency; they were only accountable for making the “right” judgements based on their professional logic. By the adoption of the logic of managerialism, a system of accountability replaced a system of trust (Almqvist, 2004). As a result, managers were given greater responsibility and became more accountable for organizational resources (Hood, 1991, 1995).

In addition, customer orientation (e.g., customised care in healthcare) became a focus in the NPM era (Bolton, 2002; Davies & Thomas, 2002; Bolton & Houlihan, 2005)). In healthcare, even in the pre-NPM era, the professions were accountable to their patients, but this was a lateral accountability between patients and physicians. However, in customised care, accountability was for patients rather than to patients (cf. Cäker, 2007). This created a hierarchical accountability in which accountability was based on created constructs of the patient and the patient’s needs (see Miller & O’Leary, 1994; Ogden, 1997). In this new form of accountability, managers as well as physicians formed the accountability network (Armstrong, 2002) that required quantified measurement of both resource-efficiency and customised care (cf. Roberts, 1991).

As a result, managerial logic, with its emphasis on administrative functions and economic measures, replaced professional logic in healthcare. Evidence of such managerialism appeared in strengthened performance standards and improved output measurements (Hood, 1991, 1995). One appeal of this new logic was that a single number could be assigned to a set of complex goals, (e.g., the ratio of patient turnover rate to the results of care activities) (Miller, 2001). Such simplified and objective quantification (Porter, 1995), accompanied by auditing and other forms of evaluation (Power, 1999), could have a significant effect on professional practices (Pollitt, 1993; Addicott & Ferlie, 2007; Sauder & Espeland, 2009). Healthcare managers could be held responsible for meeting numerical goals that did not necessarily reflect physicians’ goals of best possible patient care.

A central goal of managerial reforms is to make operations more efficient. The responsibility for achieving these results should be decentralized, and the output from operations should be transparent. The managerialistic logic characteristics, such as increased output control, decentralized result/cost responsibilities, and greater emphasis on managerial responsibilities (see Hood, 1995), are clearly visible in the CAP units. Next we describe output control, and the different accountabilities that are the consequences of these decentralized responsibilities and the increased focus on managerial responsibilities.

The possible middle-way
To better understand the possible “middle way” of outcomes, we need to discuss negotiated order as an overarching concept to bargaining as the process that may result in cooperative
strategies such as co-optation and coalition. We argue that there is also some degree of resistance in the different strategies for cooperation.

Negotiated order (Strauss, 1978) describes the outcome of conflicting interests that come into play in organizational activities. Consequently, negotiated order may produce a possible middle way of professionalism and managerialism beyond a zero sum power game. We use negotiated order as an umbrella term for understanding outcomes from the meeting between the two logics where new conditions are created. The meeting between the logics results in a new order where none of the logics “triumphs”.

Recent studies have referred to bargaining as negotiated autonomy (Burau, 2005; Parding, 2007). The professionals’ social interaction with other important actors in the workplace, where rules are invoked and available resources are defined, determines the balance between discretionary power and group control. However, in bargaining the opposing parties negotiate an agreement in direct interaction and all retain veto power (Thompson & McEwen, 1958). In principle, this is a case of cooperation with some degree of resistance. The actors who use these strategies do not actually have to cooperate.

We begin with Thompson and McEwen’s (1958: 27) general definition of co-optation: “absorbing new elements into the leadership or policy-determining structure of an organization as a means of averting threats to its stability or existence”. Co-optation in its basic form can be defined as the process by which a spokesman for a certain logic, professional or managerial, meets external strategic elements and absorbs them into policy decisions. Following Thompson and McEwen (1958), co-optation is a strategy that limits the opportunities for one party to choose goals unilaterally. They argue co-optation is called for when one party realizes it is impossible to fulfil its goals or it is possible but at a higher cost. Co-optation affects both managers and professionals. It is a control strategy because the co-opting party will prevent the other party from being equally influential in the goal setting; it is also a cooperative strategy in which the parties search for compatible goals.

A further step away from resistance is coalition, which represents the ultimate form of cooperation (Thompson & McEwan, 1958). Coalition presupposes a common purpose and a commitment for joint decisions, which is probably an unrealistic model of cooperation between professionals and administrative managers when implementing managerialistic reforms. We view these strategies on a scale from competition to coalition, with increasing degrees of cooperation. Co-optation represents more cooperation and less competition compared to the other concepts used in the literature. Informal co-optation seems to be a fruitful concept to explore different responses by the parties to each other’s competing logics. Thus, we argue that the use of the concept of co-optation provides a better understanding of

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1 Co-optation usually refers to the processes of legitimating unequal power structures by, for example, appointment of female board members to companies or appointment of native leaders to administrative posts by colonial powers. Such co-optation, in the public arena, protects the organization from destabilizing threats. This is the most known type of co-optation, called formal co-optation (Selznick, 1949).
the middle way, between resistance and decoupling, that explains why reforms eventually are institutionalized, with all their unintended consequences.

An example of co-optation in practice is Timmermans’s (2008) description of how Evidenced-Based Medicine (EBM) was introduced among clinical professionals. Co-optation at the upper professional level in a two-tier professional system standardized the lower level work of the practitioners (Freidson, 1994). This is the situation with the clinical professionals’ introduction of EBM that has allowed them to increase their knowledge base and strengthen their legitimacy (Timmermans, 2008).

Co-optation is consequently neither the result of decoupling/negligence nor the rejection/surrender of one logic for/to another. Rather co-optation is the adoption of a strategic element from another logic that retains the most important elements of its own logic.

**The ability of co-optation to transform logics**

To understand the transformation of the logics and the struggle between them, it is necessary to understand how actors create new practices and engage in practice variations (Lounsbury, 2008). Recent research on how competing logics and institutions strive for greater rationality has sparked interest in how actors enact different practices (Ibid.). Seo and Creed (2002) propose a theory in which institutional contradictions in a dialectical perspective are regarded as the driving force of institutional change. According to Seo and Creed, actors drive institutional change even when they are embedded in stable institutions. In this paper, this theory is used to gain a better understanding of how unintended consequences drive institutional change.

An explanation (see Seo & Creed, 2002) for institutional contradictions may be that groups inside the organizations are dissatisfied with current institutional conditions. According to this theory, praxis (i.e., the actors’ collective way of acting in their social context) mediates between institutional contradictions and institutional change. The actors, who are viewed as partially autonomous, as partially unreflective in following institutional norms, and as partially reflexive in evaluating alternative social patterns are ready to mobilize in collective actions (Benson, 1977). The tensions between contradictory institutional arrangements then transform the actors from passive rule-followers to active change agents. In fact, according to this theory, the contradictions explain the institutional change.

According to this interpretation, resistance and cooperation occur in the steps of the praxis formation. Seo and Creed (2002) outline these steps as follows: potential change agents are invoked; there is a reflective shift in consciousness; actors are mobilized and a new collective action takes place. However, while Seo and Creed theorize on how institutional contradictions, depending on their sources, influence the different steps in the praxis development, they say little about why the praxis development causes the change agents to take collective action (Ibid. p. 226). A more thorough investigation of these steps is needed. According to Lounsbury (2008), we should study the relationship of the logics in the
dynamics between institutions and practice. A study of unintended consequences offers that opportunity.

**Case background and setting**

Until the 1980s the public sector in Sweden was characterized by expansion with accompanying resource issues. In the last three decades numerous NPM reforms intended to address these issues have been implemented in the public sector. Since the ever-present goal of these reforms is cost savings, public sector managers, including managers of CAP units, have been held more accountable for their budgets and for greater discipline in the use of resources. Since it is difficult to predict the level of resources a CAP patient may need, resource responsibility is challenging. If the CAP unit manager allocates resources to too few patients or to the wrong patients, there is a risk to the entire patient group. Another potential danger, linked to the adoption of NPM reforms, is that when the risk to the patients becomes the CAP unit managers’ personal risk, their responses may even increase their risk (see Andersson & Liff, 2012).

Another factor that affects the psychiatric care of children and adolescents in Sweden is the change in its governing structure. At one time such care was a counselling service under municipal management. When psychiatric care was incorporated as part of general healthcare, new professions (psychiatrists and nurses) became involved and the care was controlled by healthcare legislation. Although everyday practice in the CAP units did not change significantly, there has been a movement towards identifying and formalizing management of various risks. These risks were hardly new, but a new approach to managing them evolved. Some individual(s) were not held accountable for the risks.

Power (1999) states that risk management has changed from risk calculation to risk organizing. This is obvious in healthcare where it is common to assign the management of certain risks to a limited number of people (often specific professions). In the CAP units, the psychiatrists, who are fewer in number than either the psychologists or the social welfare officers, nevertheless acquired a strong unit position because they had medical responsibility for the patients. With this responsibility, personal risk for the psychiatrists increased. A CAP unit psychiatrist describes the burden of this responsibility:

> The medical responsibility became razor sharp afterwards. Twenty-five colleagues have left over the years because they felt that the medical responsibility was too heavy.

Yet another problem resulting from the increased accountability management in the CAP units has to do with the overlap of responsibilities. Although the psychologists are the largest professional group in the units, there are many other professions involved, directly or indirectly, in patients’ care – physicians (psychiatrists), social welfare officers, nurses and administrative personnel. Each group has its own responsibility. For example, a unit manager (in this research, a psychologist in one unit and social welfare officers in two units) is accountable for using resources in a way that achieves unit goals (e.g., patient flow, treatment time). The boundaries between the two areas of responsibility – patient care and resource
economy — are not always clear. As far as responsibility, there are few issues that are entirely medical-related or entirely resource-related.

**Method**

Our study takes a qualitative approach in its investigation of how professionals and managers work in the three outcare units for child/adolescent psychiatric treatment. The CAP units are in a medium-size Swedish city. They have similar responsibilities and operate under similar conditions with comparable staffing, reception areas and other facilities. We chose a qualitative approach because it allows us to “get close” to the professionals and managers and their activities so that we can understand how they meet the increased accountability pressures. Our interviews, observations and shadowings of people engaged in complex, medical activities (e.g., Hewison, 2003) allowed us to identify their actions, choices and strategies in this environment.

Our fieldwork began in the Spring of 2007 and concluded in the Autumn of 2008. We participated jointly in the fieldwork and together analysed the data collected in interviews, observations and shadowing. Our goal was to assemble a rich and varied reflection of the actors’ lived experiences. We interviewed all employees and managers at the three units, including supervising managers (52 interviews). We also interviewed psychologists, social workers, and managers from the schools, Social Services and Habilitation Services that are the important permanent, cooperating organizations for these CAP units (10 interviews).

In our analysis of the data, we followed a process of interpretation and sense-making. Immediately after each interview/observation/shadowing, and immediately after each transcription, we noted our findings and reflections as we progressed. After the initial interviews, we listed the themes and categories that summarized the everyday work at the units.

**Co-optation practices**

All reforms to increase output control and accountability described above are co-opted in different ways by the managers and/or the professionals. When these reforms are co-opted by different actors, unintended and undesired outcomes may result. Next we examine these co-optation practices.

*Output control*

In the last five years, under the managerial logic, the CAP units have gradually been evaluated by more and more performance measurements. The goal of this measurement process is to make the output of the CAP units transparent. The main factors targeted by output control are access and quality.

The requirements for access to care have become essential aspects of healthcare. A guarantee of care applies to the total organization of which the CAP units are a part. Initially this meant that a patient’s maximum waiting time for a first visit was 90 days, and the maximum time before treatment began was also 90 days. The maximum waiting time for a first visit was
reduced to 30 days as of 1 September 2007. The decision by the CAP units’ parent organization (Västra Götalandsregionen, hereafter “VGR”) to introduce a care guarantee agrees with declarations at the national level. These declarations have since been clarified in such a way that targeted government support is now linked to a waiting time for the first treatment of 60 days (from 2010) and then to 30 days for both waiting times (from 2011). In practice, this means that the CAP units must follow the national guarantee of care standards in order to maintain their government support.

The requirements for quality and the assurance of quality work in healthcare have held an increasingly prominent position in the last five years. VGR participates in a national quality registry with public transparency so that comparisons can be made between the country’s healthcare systems (the equivalents of VGR). The business plans establish goals for how many “customers” (as the patients are identified) should report satisfaction with their treatment (a goal of about 85%). Dissatisfied patients can appeal to patient boards at the parent organization (VGR) or to an external supervisory authority. A general quality control monitoring using survey questionnaires is conducted with CAP unit patients. In these various questionnaires, the patients may evaluate their experiences with treatment and make self-assessment comments on their health before and after treatment. Since 2005, this method of quality control has gradually spread to all the CAP units.

In general, the measures to ensure “customer satisfaction” seem to create opposite effects since they are co-opted by managers and professionals. We noted that both groups focus on the patients, but we could see no transformation of “patients to customers”.

**Professional and organizational accountability in alignment**

Seemingly, the intention in dividing the responsibility between the CAP unit managers and the psychiatrists is to achieve “cooperative conflict”. They come from two different hierarchies and neither has decision authority over the other. Yet most decisions are related to both areas, which means they can block each other’s decisions. The psychiatrists make decisions based on medical reasons (quality, patient security) and the unit managers make decisions based on resource reasons. Conflicts between professions (doctors, mainly) and administration (managers) are well known. Thus, the intended effects that the psychiatrists should safeguard quality while the unit managers should safeguard resources seem likely to occur. However, we were surprised to observe an implicit alliance between the psychiatrists and managers on some issues. Together they co-opt different reforms that aim to increase their responsibilities. A clash between accountability and responsibility results, as illustrated next by their **strategic use of diagnoses**.

In general, the perception of a medical diagnosis is an objective conclusion based on the patient’s symptoms and reached through scientific reasoning. However, since a medical diagnosis has administrative implications, there seems to be space for subjective negotiation. Then psychiatrists and managers co-opt the medical diagnosis as a risk management strategy for decreasing their personal risk. The following exchange from a treatment conference where
a nurse (NUR) and a psychologist (PSY) present a patient case shows how the psychiatrist (DOC) and the unit manager (UM) negotiate over a patient referral as they ultimately deny the patient admittance. It appears that personal risk takes priority over patient risk.

DOC: Who is his physician?
NUR: [Names a physician at Habilitation]
DOC: Then he belongs to Habilitation. It’s a pity he didn’t stay there.
NUR: [The physician at Habilitation] has talked to institutional youth care, but they haven’t admitted him.
DOC: But he belongs to Habilitation. He has been diagnosed as autistic. Then they can consult CAP.
PSY: But he has psychiatric symptoms.
DOC: But that can be a part of autism as well. [The physician at Habilitation] tries to go his own way. We cannot let him throw the patient out. We must have more information. This is a mess. We must think carefully before we go into this.
UM: We can’t decide anything. We must contact Habilitation. Call them! Institutional youth care can’t refuse. Contact social services, too, before we do anything.
DOC: We must know which physician is responsible for him. Who prescribed his medication?
UM: Check Habilitation! Check Social services!
DOC: I don’t want to become the physician who is responsible for him.

We found that this pattern of patient admission refusal is typical. Different diagnoses imply administrative consequences because they mean that the patient should be assigned to a specific unit. Then the psychiatrist at that unit is held accountable for the medical risk while the unit manager is held accountable for the resource utilization. This is a form of decentralization in order to create transparency. Nevertheless, when the psychiatrist and the unit manager in alliance use diagnoses strategically they co-opt this structure in order to decrease their personal risk (for failing to meet the medical responsibility and the resource utilization responsibility).

**Professional accountability**

Even if managers are mainly responsible for the increased accountability as a consequence of the implementation of NPM reforms, different professionals are also held accountable in different ways. In the CAP units, the psychiatrists have the overall medical responsibility. This means they are accountable for all patients, including patients they have not even met. As a form of output control, the intended effect is increased patient safety. Psychiatrists are responsible for identifying patients with risk behaviour (suicidal risk, etc.) and for excluding medical risks such as brain tumours, epilepsy etc. that may have similar symptoms as psychiatric illness.

Furthermore, the professionals who treat patients (psychiatrists and psychologists) are influenced by the introduction of EBM. In EBM, each diagnosis links one or several evidence-based methods that have been scientifically shown to have positive effects.
However, this is problematic, especially for psychologists with a psychodynamic approach, because there is no scientific proof behind most of their methods. Upper management tries to encourage the professionals to use EBM, but it is not required. However, the professionals have less personal risk if they use EBM because the use of non-EBM for treatment means they are held more accountable if additional patient problems arise.

In the above exchange, the psychiatrists and the unit manager form an alliance to minimize their responsibilities through restrictive commitments to patients. Yet they remain accountable. However, the psychiatrists cannot always rely on this informal alliance and sometimes must act alone. A psychologist explains the difference between a psychiatrist’s actions and a unit manager’s actions:

Both [psychiatrist] and [unit manager] see patients as risks, with the difference that [the unit manager] tries to reduce the waiting list and have patients treated in time. [The psychiatrist] can extend the waiting time, even for people on the waiting list. She only looks for patients who are suicidal or for patients with other obvious medical risks.

(Psychologist)

The psychiatrist appears to look for “her patients” in the bigger patient group and wants the CAP unit to use its resources primarily for these patients, that is, patients who present a risk based on her medical responsibility. Consequently, her risk aversion stems from a concern for her personal risk rather than from a concern for the patient risk. This strategy, avoiding risk patients, means that the psychiatrist co-opts the reforms to increase patient security.

Organizational accountability
The CAP units have decentralized responsibility. They receive resources that depend on the estimations of number of patient visits. History is the main factor in making these estimations and therefore the resulting budget. The CAP unit managers are accountable for not exceeding their budgets. Furthermore, they are accountable for an efficient “production” in the units, that is, for waiting times, shorter treatment periods, more treatment sessions per mental health counsellor, etc. The intended effect of this decentralization is to increase the transparency of patient treatment and to make managers for accountable for resources and efficiency. It should be possible to understand how the CAP units’ resources are used.

Institutional accountability
A downside with decentralization of the CAP units is the risk that they may focus so strongly on improving their own situations that cooperation with other units and the overall functioning of activities suffer (see Liff and Andersson, 2011). To ensure that cooperation difficulties do not damage efficient patient care, a cooperation contract has been designed. All involved units – Primary healthcare, CAP units, School Support Services and Habilitation Services – have signed the cooperation agreement. This is an attempt to create accountability at the institutional level and to improve the cooperation between the different organizations with the overall goal of improving the quality of patient treatment and the reduction of patient waiting times.
In the previous example, when the psychiatrist and the unit manager in alliance *use diagnoses strategically*, the form of co-optation is also at the institutional level since the co-operation agreement is co-opted. Another strategy with similar consequences is to *require further investigation* by referring units, as illustrated in the following excerpt from a treatment conference:

**DOC:** How did you feel about the girl?
**PSY:** She is worried, avoiding … there needs to be an investigation.
**DOC:** It would be good with a written statement from her school on how she is in school.
**UM:** We have requested an investigation from her school.
**DOC:** Good, I support that.
**UM:** She is on the waiting list for investigation.
**PSY:** OK, should we say to her school that we need an investigation from them?
**UM:** Yes, and we can say to the parents that she is on the waiting list. We have to resist. They [her school] are trying something here.

By insisting on the investigation, the team members place a restrictive commitment on the patient by deciding to ask for more data from the referral unit (in this instance, the patient’s school). The conversation may be interpreted as co-optation by the psychiatrist who uses an administrative tool as a strategy to postpone treatment and to limit his obligations. Because of the urgency of the situation, the administrative tool is unchallenged and is mechanically applied, despite the loud protests we observed from the school support unit. The dominant profession co-opts the NPM administrative tool and thereby institutionalizes it.

The consequence of both the two strategies described above is restricted admittance for certain patient groups (multi-patients with several and/or blurred symptoms that can easily be referred to another unit). These patients become the “Old Maid” that no unit wants to be stuck with. It is not only the CAP units that act in this way. All associated units (Social Services, School Support Services and Habilitation Services) act similarly in order to “protect their boundaries”. All organizations co-opt the cooperation agreement with their own interpretation of and support for the agreement. This is possible because there is no “judge” in the system who can decide who is right when different parties disagree. The cooperation agreement is co-opted and does not influence the “Old Maid” game.

**Analysis**

Co-optation offers a different explanation of the effects of managerial control attempts on professionals than the dominant explanations such as de-coupling, colonization and resistance. The de-coupling explanation is based on the understanding that nothing really changes (other than at the surface), but the co-optation explanation implies there is real change, even if actual effects are different than the intended effects. The reason is that strategic actors co-opt the reforms and act within their free space for manoeuvring. Co-optation practices can consequently explain the unintended consequences of managerialistic control attempts. These practices may also explain the puzzling fact that, despite decades of
failed NPM reforms with no results (according to de-coupling-based research), the public sector has obviously experienced a radical transformation.

Unlike the colonization explanation, which is based on a view of professionals as victims destroyed by “evil management” (managerialism), the co-optation explanation sees professionals as active, interpreting, strategic actors who use reforms in their interests. The colonization explanation paints a gloomy picture of future public services where their mission values have been destroyed. The co-optation explanation implies a different public service compared to today, but one that is not necessarily worse.

Finally, the co-optation explanation differs also from the resistance explanation. Even if it is possible to view co-optation practices as a form of resistance, professionals do not seem to resist the reforms. Because they co-opt the reforms, there is no need to resist them. By showing that co-optation exists and is a commonly-used mechanism, we do not claim that de-coupling, colonization and resistance do not exist. They are also important mechanisms that can explain events in the public sector. Co-optation is not the only explanation, but it has central importance.

As we noted above, there is little evidence of resistance to managerialism among the professionals in our study. The CAP units attempt to meet accountability demands such as increased patient streaming, shorter waiting and treatment times, and more patients assigned per counsellor. The CAP units also provide more quantitative performance reporting on both the units and the healthcare providers. There is also greater emphasis on staying within budget.

Furthermore, the professionals are also expected to meet their professional demands for accountability. These include prioritization of direct patient care over reporting and other administrative tasks, greater concern for patient welfare than for economic considerations, and provision of therapy according to modern scientific methods that have a prospect of good success. In addition, patients at risk of suicide must be assessed and given highest treatment priority.

Both the CAP unit managers and the professionals seem to be accountable to all of these sometimes-contradictory goals. The implicit alliance between the managers and psychiatrists is achieved by use of these strategies:
1. Admission denial and referral for unsuitable patients
2. Concentration on psychiatric patients
3. Refinements in the patient treatment

For both administrators and medical professionals, we observed these strategies meant that they could be held accountable. Through co-optation, the administrative reforms have influenced the professions’ capability for providing better patient care. This result is accomplished by the actors’ use of institutionalized tools. These tools include formal positions, medical responsibilities, budgets and patient diagnoses that promote shared
individual interests between the professionals and the team leaders (creating efficient, frictionless production and high professional status in the CAP units). Consequently, administrative demands and professional obligations are largely reconciled by mutual agreements. In this way, administrators and professionals work together by using each other’s reasons to validate their own positions without invalidating those of others. In short, they use mutual co-optation.

The consequence is a restrictive admittance policy for certain patient groups, which enables the CAP unit managers to maintain efficient patient streaming and the psychiatrists to decrease their personal risk of medical failure. The use of institutional tools is required because, for example, lack of resources is not considered an acceptable reason for patient restriction. In such patient decisions, the CAP unit managers co-opt the medical profession’s diagnosis in order to achieve the units’ financial goals while the psychiatrists co-opt the administration’s budget and resource arguments in the internal discussions in order to avoid admissions of high-risk patients. The patients are thus constructed according to the limits of unit capacity and unit competence. Since denied admissions are described “objectively”, using diagnoses and professional jargon in the reports, medical rather than economic justifications are used.

Perhaps the most interesting issue related to co-optation is the fact of its existence. How is it possible to co-opt reforms and use them on behalf of self-centred interests? The co-optation practices that we describe have one commonality that should be emphasized. They are all based on institutionalized tools such as budgets, medical responsibilities and diagnoses. Using these tools legitimizes and institutionalizes actions.

On the whole, our study provides no evidence of the conflict that is typically said to exist between managerialism and professionalism in healthcare. We found that the use of professionals does not necessarily threaten an organization’s ability to manage its resource limitations. We also found that managerial control models pose relatively few problems for the professions in their various activities because they co-opt them.

**Conclusion**

In this paper we have illustrated how professionals co-opt managerial logics and managerial techniques that drive their professional interests. Co-optation of budget/resource arguments enables exclusion of patients, and thereby decreases the professionals’ perceived medical risk. With the co-optation of the organization’s formal routines and rules (in the name of EBM) patient treatment results in the transfer of risk from the professional to the organization. Co-optation can thus explain the unintended consequences from managerial reforms because it views professionals as active, interpreting, strategic actors who use reforms in their own interests. In this way, co-optation can describe how a negotiated order between managerialism and professionalism appears. This is then a negotiated order that goes beyond nothing happens (de-coupling) or professional values are destroyed by managerialism (colonization). It is possible to view co-optation practices as a form of resistance, but it is a very subtle
resistance that is better understood as a form of interaction. Professionals do not need to openly resist the administrative reforms since they can co-opt them.

Our study has some practical implications for healthcare. We have shown that the co-optation of managerialism can serve (or not serve) the best interests of patients. On the downside, co-optation seems to increase the risk that difficult-to-diagnose and difficult-to-treat patients will fall by the medical wayside. When accountability pressures increase, professionals respond with claims of increased productivity in simple output terms, such as through-put time and availability. At the same time, they neglect the wider definition of patient-centred care, for instance, by not seeking collaboration with other care providers or by using holistic approaches that are in the best interests of patients. This paper illustrates that consensus is possible between administrative management and health professionals – the two groups often regarded as opponents.

References


