The multi-professional team as a post NPM control regime. Can it integrate competing control regimes in healthcare?

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Abstract

This paper focuses on multi-professional teams (MPT) as a potential post New Public Management (NPM) control regime in order to develop individualistic and holistic care in healthcare in the context of two competing logics: managerialism and professionalism. In a qualitative case study, three outpatient Child and Adolescent Psychiatric (CAP) care units are investigated using interviews, observations and shadowing. The study shows that the MPT has an integrative effect on the two logics when informal alliances are formed between psychologists/psychiatrists and unit managers. We conclude that the MPT may achieve patient care in a resource-effective and professional way but not individualistic and holistic care. An explanation may be that individualistic and holistic care is neither measurable/quantifiable as required by the resource-effectiveness goal nor in focus as a consequence of the logic of professionalism. A theoretical implication is that the negative effect of NPM on the professionals' autonomy is mitigated by the MPT. Earlier studies may have underestimated the importance of "hard facts" introduced by a strong control regime, in this case, the NPM context. The control regime may take over and create collaboration; nonetheless, the outcome is not entirely the desired one.

Multiprofessionella team som post NPM styrregim
Kan de integrera konkurrerande styrlogiker inom hälso- och sjukvård?

Denna artikel fokuserar på frågan om multiprofessionella team (MPT) kan ses som en potentiell post New Public Management (NPM) reform och uppnå både effektivitetsideal som NPM-reformer eftersträvar och intentioner om en individanpassad vård där patientens samlade behov av vård och stödinsatser beaktas. Intervjuer, observationer och skuggning har använts för att studera betydelsen av dessa logiker för samarbetet i tre enheter inom barn- och ungdomspsykiatrin (BUP). Studien visar att MPT har integrativa effekter på de två logikerna. Den negativa effekten av NPM på de professionella utövarnas autonomi underlättas av arbete i MPT. MPT kan leda till en vård som både är resurseffektivt och professionellt utförd, men intentionerna att bedriva en individualiserad och behovsanpassad vård är svåra att uppnå till följd av det ökade ansvaret för att uppfylla effektivitetskrav. Tidigare studier kan ha underskatta den styrande effekten av kvantitativa effektivitetsmått som NPM inför. En förklaring kan vara att graden av patientorienterad och holistisk vård inte kan mätas med kvantitativa mått som NPM regimen kräver och inte heller fokuseras som en konsekvens av professionslogiken. Det innebär att MPT som post NPM reform motverkas om inte de höga, kvantifierade NPM kraven på resurseffektivitet reduceras.

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Introduction

The interest in developing public sector governance appears to have increased greatly since the expansion of the public sector ended at the beginning of the 1970s (Hasselbladh et al., 2008). New Public Management (NPM) is the umbrella term for managerial methods based upon competition, marketization and managerialism that have been used in these development efforts with the main purpose of creating resource-effective production and customer orientation (Hood, 1991 & 1995; Barzelay, 2001; Almqvist, 2004). The reforms have dealt with subjecting public organizations to competition, with creating competitive profit centres in public organizations, with controlling the profit centres through contracts, and with creating order and performance structures, all according to industry and market models (Brunson 1989; Hood, 1991 & 1995). This split up, which is deliberate, is intended to separate departments into "single purpose organizations" in order to achieve increased accountability (Hood, 1995). However, such decentralized responsibility where smaller organizations work with their goals in isolation from each other has created coordination problems (Osborne & Gaebler, 1993; Pollitt & Bouckaert, 2000; Peters, 2001). During the last decade, NPM reforms have addressed the problem of disintegration between such organizational units, and reforms have sought to better coordinate the units' work, both vertically and horizontally. These post-NPM reform efforts have initially been labelled "joined-up government" and also "whole-of-government" (Christensen & Lægreid, 2007). The reforms have aimed at the coordination of activities but also at the structural integration of activities in new organizations.

In the healthcare sector, which this study concerns, with its strong and dominance seeking professions (Freidson, 1970), the professional logic based on judgement (Timmermans, 2008) was long the dominant control regime in hospitals until it met the rival, business-like NPM logic based on quantification (Power, 1997). In this study we contrast the NPM logic and the professional logic in situations where NPM often views the professions as a problem (Pollitt, 1993; Ferlie et al., 1996; Thomas & Davies, 2005).

New control regimes, defined as budgets, performance measurements and administrative accountability chains, all of which aim to control the professionals in the new practice regime (Hasselbladh et al., 2008), tend to manage employees through evaluation and control of their actions. One result is the formation of new institutions in organizations. When Oborn and Dawson (2010) argue that the MPT is an institutional response that enables translation of knowledge across occupational boundaries as a way to generate innovation and improve performance, the MPT seems to reflect such modern and relatively untested systems of control that assume there is good integration between systems of control and systems of practice.

In healthcare, the creation of the MPT can be seen as a way to create the necessary favourable conditions for collaboration among the professions in their work around patients treated in common. Such teams should increase the chances of early diagnosis and proper treatment for patients following the professional

logic. The MPT should also apply management by objective principles to economic and performance matters following the business-like NPM logic. Team leaders who can successfully combine the team members and their own professional roles with the administrative roles should lead the MPT. That is why the MPT may be seen as an expression of a post-NPM reform (as defined by Christensen & Lægreid, 2007) used to introduce a third logic, collaboration, which aims at the integration of the two previous logics.

Control problems are thought to exist even when professionals work in team-like constellations, such as healthcare departments, and when the teams are composed of representatives from different organizations (Øvretveit, 1993; Blomgren, 1999; Levay, 2003). There is always a risk that a lack of clear leadership will increase the friction between different members of the team (Berlin & Carlström, 2008). Payne (2000: 186) concludes that 'multiprofessional work is not an easy answer to the problems of coordination and collaboration which assail health and social care services'. We seem to know little about how MPTs work in a NPM context in healthcare (Payne, 2000; Larkin & Callaghan, 2005; Berlin, 2010; Berlin & Carlström, 2010). This is especially true when we view the MPT as a post-NPM control regime.

We suppose there are different logics in a healthcare context in operation at the same time as layers form upon each other from different periods (Reay & Hinings, 2009). This creates a complex control regime in which there are great difficulties in foreseeing the outcome. The pre-NPM era, with its professional control regime based on judgement, has received a layer of NPM control regime, oriented towards resource efficiency, customised care and accountability based on quantification. The post-NPM control strives for integration between these control regimes.

From a structural perspective, the MPT is an example of a post-NPM reform (see Egeberg, 2003). At issue is the question of whether a MPT can achieve its reform goals since a MPT does not focus on building collaboration based on unified and cultural values (Ling, 2002). That is the question investigated in this study: whether a MPT transforms the system in which it is used or whether it simply rebalances elements within that system (see Gregory, 2006; Halligan, 2006). In the MPT, the competing institutional logics are enacted and represented by the team members who may influence the collaborative outcome (Bryson et al., 2006).

The aim of this study is to investigate how a MPT can integrate the two competing control regimes (professionalism and managerialism) and whether a MPT can achieve the intended consequences of providing individualistic and holistic care given the context of managerialism and professionalism. The study investigates whether the concept of MPT, which is an integrated structure, integrates the two *logics* such that a qualitatively better result may be achieved than can be achieved by the mere introduction of managerialism. It is only then that a MPT can be regarded a "true" post-NPM concept.

In this study, we investigated MPTs in three outpatient Child and Adolescent Psychiatric (CAP) care units where there is a very real need for individual

and holistic care, particularly when patients' mental illnesses often appear in combination with severe psychosocial problems. We use the definition of individual and holistic care from SOU: Immediate care services based on care-takers' individual needs that require a holistic view of the care-taker based on collaboration between several different actors (SOU 2006:100).

These patient care ideals may be part of the professional service ideal. The CAP unit teams should respond to patients who are at high medical risk by making timely assessments, prioritizing them in the system, and providing high-quality care. At the same time, the teams should meet the demands of NPM reforms: resource efficiency that depends on increased patient streaming and more patients assigned per therapist. In addition, the teams should be more patient oriented by working to shorten waiting and treatment times. A successful integration of the two logics may mean improved individual and holistic care. A post-NPM structure should provide a better result better than is likely from using just one of the two logics.

The next section presents the three different logics of control as the theoretical frame of this study that is applied in the analysis of the empirical data. First, the research method is described followed by a description of the setting for the different logics of control. Thereafter the three logics are illustrated and the meeting between them is described. The last section discusses the findings and presents the conclusions.

Three logics of control

Our study, which contrasts the NPM logic with the professional logic, describes their meeting in a MPT context. We begin with a description of the three logics of control in healthcare: professionalism, managerialism and collaboration.

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 since 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 profes-

sions 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; Freidson, 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.

Collaboration

A large body of literature on collaboration, especially from the last decade, is available (for a review, see Bryson et al., 2006; McGuire, 2006). According to McGuire (2006), researchers have focused on the identification of the skills needed for collaborative efforts and on the outcomes of collaboration programmes. There are a numbers of studies that examine work-based collaborations and the collaboration process among stakeholders, including partners (see, for example, Thomson & Perry, 2006; Ansell & Gash, 2007), as well as network-based collaborations (Head, 2008).

The post-NPM era can be seen partly as a path-dependent development of NPM and partly as a resistance to NPM (Christensen & Lægreid, 2007). The concept of post-NPM implies an ambition to integrate disintegrated units. Integration, and thereby collaboration, became an issue. While this meant a combination of hierarchical and lateral accountabilities, integration also became a goal in itself, independent of the two underlying streams it was intended to integrate. The MPT, as a concept, is a good example of post-NPM logic aimed at a structural integration (Andersson & Liff, 2012). The question is whether the MPT becomes a way to control the integration of different logics. If the concept of the MPT enables this integration, it can be regarded a true post-NPM concept.

At present, the logic of multi-professional collaboration in a tight structure such as a CAP MPT is relatively untested. Despite the existence of various types of MPTs in healthcare, we do not know whether they integrate the different logics. For example, Payne (2000) describes such multi-professional collaboration models in primary care where primary healthcare teams (PHCT) consist of general physicians, healthcare centre nurses and community social workers. On the whole, however, the collaboration between physicians and social workers is a relatively marginal consideration in such practices. Moreover, related to the PHCT network of semi-independent professionals (Payne, 2000), a number of studies report collaboration difficulties in their networks (Payne, 2000; Larkin & Callaghan, 2005).

In Sweden, CAP units, such as the three units in this study, are also modelled on the idea of multi-professional collaboration that is intended to enable translation of knowledge across occupational boundaries. The focus is on integration of the various occupations achieved through collaboration based on micro systems used in the day-to-day work of patient care.

In Table 1 we summarize the meaning of accountability, focus, logic, and the basis for exercising the logic in the three eras.

Table 1. The three logics of control

Era	Accountability	Focus	Logic	Basis
Pre-NPM	Lateral	Judgement	Professionalism	Professional competence
NPM	Hierarchical	Measurement	Managerialism	Organization structure
Post-NPM	Lateral/hierarchical	Integration	Collaboration	Micro systems

We have defined the three eras as pre-NPM, NPM and post-NPM. However, the control logics of the different eras do not disappear with the arrival of a new era. Instead, the new control logic is added to the existing control logic and thereby the complexity increases (Andersson & Tengblad, 2009). The co-existence of different – and in many times competing – control logics makes administering public sector organizations difficult.

Method

This study addresses how a post-NPM reform integrates managerialism and professionalism. A prerequisite for such a study is to understand the actions of different actors and the strategies that emerge when there are different logics of control. Therefore, we performed qualitative, interpretative field studies since they allowed us to achieve the closeness to the action. The data collection took place during 2007 and 2008 in three CAP units in Sweden and was performed by two researchers. We selected these units because the units' upper management regarded the units as "well-functioning". This evaluation meant the units used their resources effectively. Thus it is probable that several competing logics of control are present in the units. We conducted 62 interviews, made 11 half-day observations and shadowed employees for two days (on "shadowing", see Czarniawska, 2007). All employees at the units were interviewed. In addition, we interviewed upper level unit managers and representatives (such as school psychologists, psychologists and social workers) from important collaboration units (support units at schools, Habilitation services and social services). We made our observations mostly at treatment conferences (TCs) where CAP unit personnel gathered to discuss patient treatments.

The interviews dealt with individuals' experiences of work, collaboration, managers, management, other professions, and so on. Our observations at the TCs revealed professional and/or individual strategies and attitudes since the discussions of patients' treatments involved several professions and the manager. We also asked respondents about their work and about events we observed at the TCs since we found it useful to talk about these events that we had experienced together. The discussions became richer in this way as we knew that we were talking about real events and not the respondents' "theories about the world".

All interviews were audio-taped and later transcribed. Detailed field notes were taken at the observations at the TCs since audio and video recordings were not permitted. Notes were also taken on the participants' comments after the conferences (when they gathered for coffee) before leaving the setting (see Bry-

man, 2008). Each day's field notes were edited and printed the day after the observations (see Merriam, 1998). This documentation totalled more than 300 pages.

We analysed each interview and observation directly after its conclusion. We then combined this first impression analysis with our field notes. The interviews and observations were thus influenced by this first-order description (Van Maanen, 1988) and by our interpretations of previous interviews and observations. By combining and interpreting the results from interviews and observations, we gradually understood the use of the actors' sensemaking process. As we read and re-read this documentation, we looked for themes that reflected important aspects of the work in the CAP units.

For each CAP unit, we categorized the empirical data we found interesting as a way to understand the team members' sensemaking process. Our two-person research team was useful in the data analysis since we naturally engaged in discussions with each other on the content and interpretation of the data collected in the interviews and observations. Through this process, we reduced our empirical data to a fifth of its original volume. We also created a list of themes that related to the study's theoretical framework. For example, when we found different bases for action strategies in the transcribed text, we used a theoretical framework of different logics of control to understand what happened. The empirical data influenced our choice of theoretical framework and the theoretical framework guided the categorization process. The quotations used in the next empirical section are chosen because they are relatively clear examples of what we aimed to illustrate. They are not, however, single events; rather, they are examples of typical events.

Settings

The mission of the CAP units today is to provide coordinated, competent psychiatric care, generally for patients age 18 and under. Formerly, the CAP units acted simply as childcare advisors, but now their role has expanded to include child and adolescent psychiatric care. With this change in role, new professions (psychiatrists and nurses) have joined the teams that originally consisted only of psychologists, social workers and administrative personnel. Different logics of control, described next, are evident in these CAP units.

Professionalism

Legislation by the Swedish government (SOU 2006:100) has influenced the transformation of the outpatient CAP units from advisory bureaus (primarily for child rearing issues) that also offer family and individual therapy to multi-professional healthcare organizations. Socialstyrelsen (Swedish National Board of Health and Welfare) stipulates the requirements for patient security. The enforcement of these requirements rests with HSAN (Swedish Health and Medical Responsibility Board). The main governing principle is that all treatment professionals (therapists, psychologists, nurses and psychiatrists) have a responsibility

for the care they provide to patients individually in accordance with the logic of professionalism. In addition, Socialstyrelsen and HSAN require the psychiatrists to be involved with all patient cases – their diagnosis and the initial plans for care. Socialstyrelsen states that, as a rule, there should be an attending psychiatrist for every patient. Thus, in recent years, healthcare legislation has assigned increasing patient responsibility to the psychiatrists (Swedish Association for Child and Adolescent Psychiatry, 2007). Punishments for malpractice are sanctions, warnings or license suspension.

Therefore, the role of these outpatient CAP units in the treatment of mental illness is no longer primarily that of the health care advisor for child rearing and other family issues. The outpatient CAP units are now required to take responsibility for managing the growing number of neuropsychiatric examinations and treatments as well as for introducing new therapeutic methods. Thus, the CAP units in Sweden have introduced Cognitive Behaviour Therapy (CBT) (O'Donohue et al., 2003) in addition to the well-established Psychodynamic Therapy (PT) (Caligoret et al., 2007). This change in the CAP units from advisory units to specialist healthcare units, the so-called Level 2 organizations (Level 1 organizations are the primary healthcare units), reflects the recent developments in pharmacology research and the rapid advances in psychiatric care. The CAP units are expected to exhibit *professionalism*.

Managerialism

Since 2002, under NPM, the CAP units have been evaluated increasingly by performance outcomes and economic governance measurements. As a result, in this decentralization of responsibility, CAP unit managers have become accountable for their units' resource utilization. Possibly the most important accountability element related to resource utilization for a CAP unit is its approved economic framework (i.e., generally a budget of about six million Swedish crowns per unit). However, about 90% of all costs in CAP units are salaries and office costs, few of which are variable, while the remaining 10% of costs are for training and purchased services. This means that total costs are largely fixed and can be influenced only to a rather limited extent, primarily in connection with staff departures.

Budgeted revenues are a second accountability element. Such revenues are based on the total volume of treatments established by the hospitals' purchasing departments. On average, a CAP unit provides about 3000 treatments a year (e.g., doctor visits, conversation therapy sessions). A substantial part of the economic control in the CAP units is therefore linked to the management of the productivity in these treatments. Control is exercised at the individual level so that each therapist records the average number of treatments given per day by professional category (about two patient treatments per day).

In recent years, 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. At one time, this meant that a patient's maximum waiting time, both for a first visit and before initial treatment, was 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 (the county council) to introduce a care guarantee agrees with national mandates. These requirements have since been clarified so 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 national guarantees of care standards in order to preserve their government support.

The requirements for quality and the assurance of quality work in healthcare have become increasingly important in the last five years. The regions participate in a national quality registry with public transparency so that comparisons can be made between regional healthcare systems. The activity plans for the units establish goals for how many "customers" (as 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 or to the external supervisory authority (HSAN). 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 CAP units.

Yet a potential problem from the increased accountability management in the CAP units relates to the overlap of responsibilities. Each group of professionals has a separate treatment responsibility. Each CAP unit manager (in this research, a psychologist in one unit and social workers in two units) is accountable for using resources in a way that achieves unit goals (e.g., patient flow, treatment time). The boundary between the two areas of responsibility, patient care and resource efficiency is not always clear. This is especially true for the psychiatrists who have medical responsibilities (quality, patient security) and for the unit managers who have resource utilization responsibilities. As far as responsibilities, there are few issues that are entirely medical-related or entirely resource-related.

Collaboration

To provide the required coordinated care, members of MPTs in the CAP units must collaborate both internally and externally in the treatment of mental illnesses in young children and adolescents. A CAP unit is at the centre of a healthcare environment where internal collaboration among its various team professionals is essential and where external interaction with outside organizations is increasingly important.

In this MPT collaboration, each professional practice has an independent and specialized competence in the shared patient treatment. While laws and professional standards regulate the team members individually, their successful collaboration requires a form of activity-spanning across their competences, that is, a boundary-spanning activity around the patient. The principal boundary-spanning activity is the Treatment Conference (TC) where the various profes-

sionals – medical and non-medical – discuss the patient cases. At the TCs, each therapist, one after another, presents a patient case. After each presentation, there is a discussion of the patient's current treatment, difficulties encountered and future treatment concerns. Each therapist who presents a patient case represents a mini-team of two therapists – often a psychologist and a social worker – assigned to the patient. The mini-team's responsibility is to collaborate around the patient in diagnosis and treatment. The CAP unit manager, acting as a *team leader,* and the other team members take part in the discussions by offering advice and asking questions. By the end of each patient case, the therapists are supposed to reach conclusions about their patients' future treatment. Then the next therapist presents her/his patient case, and so on.

Expressions of the logics of control – empirical summary

In this section we describe the three logics of control. Then we present our finding from the meeting between these logics in the three CAP units.

Professionalism

Since there are several professions at work in the three CAP units, it may be difficult to describe only "one" logic of professionalism. However, we have identified the following elements that are common to all the professions represented in the CAP units:

- extensive training in treatment methods for each profession
- supervision by external supervisors for each profession
- recognition of the importance of diagnosis prior to evidence-based treatment methods

In addition, the different professions in the CAP units focus on their individual spheres of professional competence rather than on the professional competence of the team as a whole.

Managerialism

Managerialism is highly institutionalized at the CAP units as a natural part of the everyday practice. All three CAP units are successful in meeting the following required NPM performance measurements: budgets, patient turnover rates, number of treatments, average number of treatments by day and by professional category, waiting times for a first visit and first treatment, and patient satisfaction. For this reason, upper management regards the ÇAP units as administratively "well-functioning".

Collaboration

The organization of a MPT in a CAP unit, as previously described, aims at promoting collaboration among the various professionals and managers, both internally and externally. Collaboration is necessary in patient diagnosis and treatment, in best utilization of resources and in the work with the various supporting

institutions. Collaborative efforts by the MPTs include the bi-monthly TCs and the cross-professional mini-teams of two therapists assigned to patients. Our study noted one format – the "helpful question" format – that is often used in the TCs. In this format, therapists asked other therapists about their patient treatment decisions, but they did not challenge or criticize these decisions. However, this format, supportive in its collaborative intent, may not always be in the best interests of the patients. More analytical criticism may sometimes be more effective in revealing the need for changes in treatment, ultimately leading to better treatment.

The meeting of the logics of control – empirical evidence

The concept of the MPT obviously aims at structural integration. However, the focus of this study is if and how the MPT control regime integrates the competing control regimes of managerialism and professionalism. It was clear there was evidence of all three logics at work. In particular, we looked at how the logic of collaboration achieved integration between the logics of professionalism and managerialism. We were surprised to find that while collaboration does indeed create an informal alliance on patient admissions and treatment between managerialism and professionalism, improved individual and holistic care is not necessarily the result. The following two examples make this point.

Example 1. Restricting admissions by requiring information
In several TCs we observed the creation of informal alliances between medical personnel   and unit managers in order to restrict patient admissions. In the following example, there is an exchange in a TC between a psychiatrist (DOC C), a psychologist (PSY A) and a unit manager (UM D) concerning a patient referral.

> DOC C: How did you feel about the girl?
>
> PSY A: She is worried, avoiding … there needs to be an investigation.
>
> DOC C: It would be good with a written statement from her school on how she is in school.
>
> UM D: We have requested an investigation from her school.
>
> DOC C: Good, I support that.
>
> UM D: She is on the waiting list for investigation.
>
> PSY A: OK, should we say to her school that we need an investigation from them?
>
> UM D: 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.

In this exchange, the three participants require an investigation before admitting the patient. Thus, they delay admission by deciding to ask for more data from the

referral unit (i.e., the school). In an interview, a school psychologist criticized this process:

> The implication of CAP's behaviour is that we will always perform a cognitive capacity test, even in cases when we think there are other factors causing the problems. […] The reason seems to be that we should have done all things that are possible before they take over. Previously this was for children with complex multi-problems, but now it has become a standard procedure for all patients. […] We [school psychologists] have discussed this and we think that CAP is trying to establish a filter so that they can restrict their activities to focus on specialized cases.

There is an implication that the CAP unit may be thinking more about its own workload and its power position than about the patient. The same school psychologist continued:

> We school psychologists think that it is important to look at the whole situation, not only at the results from the cognitive capacity test. The dialogue and the conversation with the child and the parents are important, whether the test is given or not. The parents usually think this [the dialogue and conversation] is more important than a test. We don't want a bureaucratic system where you begin with a diagnosis. When you are dealing with children's medical condition, diagnosis is maybe what you want. But when you are dealing with children's psychiatric state, maybe just talk is needed, at least in the beginning – then the talk can lead to something else.

This example reveals how a policy of restricted patient admission may reflect the logics of both professionalism and managerialism. By requiring more investigation before admissions, the CAP unit professionals can play up their specialized competences: this is the logic of professionalism. Delaying (even refusing) admissions also conserves limited resources: this is the logic of managerialism. The collaboration between professionalism and managerialism thus satisfies everyone since it allows both the medical personnel and the unit manager to demonstrate their respective accountabilities. Yet, as the next example, shows, individual and holistic care suffers.

Example 2. Restricting admissions by "diagnosis management"
Another way to restrict admissions is to refer patients elsewhere. Such referrals follow negotiations among personnel about patients. In general, a medical diagnosis is considered a scientific conclusion based on an evaluation of the patient's symptoms. However, administrative considerations in the healthcare setting may also influence a medical diagnosis (see Bowker & Star, 1999). At this point, objective rationality meets subjective decision-making as the logic of professionalism meets the logic of managerialism. In the following example, there is an exchange in a TC among a psychiatrist (DOC D), a psychologist (PSY A) and

a unit manager (UM F) as they negotiate over patient. A nurse (NUR B) is in the TC but is not involved in the negotiation.

> DOC D: Who is his physician?
>
> NUR B: [Names a physician at Habilitation]
>
> DOC D: Then he belongs to Habilitation. It's a pity he didn't stay there.
>
> NUR B: [The physician at Habilitation] has talked to institutional youth care, but they haven't admitted him.
>
> DOC D: But he belongs to Habilitation. He has been diagnosed as autistic. Then they can consult CAP.
>
> PSY A: But he has psychiatric symptoms.
>
> DOC D: 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 F: 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 D: We must know which physician is responsible for him. Who prescribed his medication?
>
> UM F: Check Habilitation! Check social services!
>
> DOC D: I don't want to become the physician who is responsible for him.

In this exchange, the psychiatrist and the unit manager agree that since the patient has symptoms of autism, he should be referred to Habilitation services. The psychologist's weak objection that the patient has "psychiatric symptoms" is overruled by the agreed-upon diagnosis of autism that includes such symptoms. In an interview, another psychologist (with some ten years' experience at Habilitation services) offered the following critical commentary on such patient admission refusal:

> Sometimes we [at Habilitation services] wonder what CAP really does? What is required before they think they ought to help? […] CAP's diagnostic capability has really developed during the last ten years, but I think it has led to an enormous increase in diagnoses of autism by CAP. One cannot help wondering whether it is a situation of over-diagnosis. Either CAP has improved its diagnosis of autistic symptoms, or they want to avoid untreatable and difficult cases. This suspicion poses a risk to the collaboration between our organizations. On the other hand, if there is an increase of autism among children, we need more resources.

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Analysis of the two examples

In both examples, the psychiatrists and the unit managers agree to restrict patient admission. They allied themselves as professionals and as managers, although for different reasons. However, in both examples the CAP units' medical personnel couch the restrictions in medical terms: there is insufficient information on the patient's condition; the patient's diagnosis requires alternative treatment. The result is that the patients are directed to other organizations for treatment or for information collection. However, as the Habilitation services psychologist observes, this strategy may place the patient at risk. Moreover, the suspicion that arises as to motive clearly jeopardizes the benefits of collaboration. It is arguable that organizations other than the CAP units may be better suited to care for certain patients, which again is consistent with the logic of professionalism. However, this argument, rarely made, is convincing only if there is a clear explanation why patients should be directed away from the CAP units.

The CAP units' managers also use medical reasoning rather than economic reasoning to justify this strategy of turning away patients from the CAP units. They appear to recognize that the argument of insufficient resources has no medical legitimacy in limiting patient admissions. The recently introduced guarantee of patient admission within three months from the first contact is intended to reduce waiting times. However, given the unit managers' position on patient admissions in the TCs (even if within the three-month guarantee), the goal has become "within three months" rather than "as fast as possible".

In commenting on the division of work between the CAP units and Habilitation services, a CAP unit psychologist described the external collaboration and its consequences for patients, particularly with reference to how diagnoses are used administratively:

> Habilitation services is responsible for autistic children who attend special schools. But it is often hard to say what is what, so the diagnosis becomes a procedure that places the child somewhere. […] Children with several possible symptoms risk being sent back and forth between CAP and Habilitation services. Often the wish is for good collaboration, but it is difficult when the resources are limited.

A school psychologist offered a similar criticism:

> We [the schools] and Social services often complain about CAP: what do they really do? The expectations are often high, but often so is the disappointment. […] I think it is somewhat person-related whether it becomes a CAP case or not – if they are interested in the specific problem or not. As a new school psychologist you need to learn the tactics. […] The therapists [at CAP] act based on their special interests that seem based in their education. CBT psychologists offer treatment based on CBT, while the trained social workers see family problems in every situation.

These comments are directed toward the policy of "diagnosis management" that is used to restrict admissions that may not be in the best interests of patients.

Restricted treatment

Since unit managers are accountable for waiting times and treatment times, the "preferred" CAP patients are those with specific symptoms that are treatable with predictable results. When patients with very complex symptoms are admitted, the unit managers have to worry about budget limitations. Such "multi-patients" who have several and/or blurred symptoms may require treatment for several years. We observed that the unit managers often promote short, standardized treatments for such patients on the waiting lists. These treatments allow the unit managers to conserve resources.

One tool unit managers use to conserve resources is the new tool called the "5-1" for patient treatment. Using this tool, 1 to 5 standardized patient-therapist meetings (and no more than 5) are scheduled for each patient. While this tool is intended for use with patients with less complex diagnoses, it has also been used in more complex cases. One therapist reported satisfaction with the use of the 5-1 tool: 'It is good because it is easier to know when we have done what can be expected of us'.

While the unit managers are responsible for waiting times and treatment times for all patients, the psychiatrists have medical responsibility mainly for the patients they see as "their patients". The psychiatrists appear to look for "their patients" in the larger patient group and want the CAP units to use their resources primarily for these patients.

Conclusions

In this study we illustrate how the logic of managerialism that was introduced by NPM complemented rather than replaced the previous logic of strong, autonomous professions and their ambitions to exercise professionalism. We show that the two logics have an impact on the managers' and team members' ways of working. It seems the MPTs have become more resource effective when they meet upper management's quantified expectations. It also seems that the logic of professionalism is steadily developing. In using MPTs, with their aspirations to integrate these two logics, a third logic is introduced. Our study focused on whether the MPTs achieve the intended consequences of providing individual and holistic care given the context of managerialism and professionalism, and whether the concept of the MPT integrates the two logics in a way that creates a qualitatively better result than is achieved by the mere introduction of managerialism. If the concept of MPT enables this integration, it can be regarded a true post-NPM concept.

This study shows that the MPT concept has an integrative effect on the two competing logics. As our representative examples reveal, informal alliances formed between psychologists/psychiatrists and unit managers. In these informal alliances, the psychologists/psychiatrists tended to restrict admittance for pa-

tients requiring diagnoses and treatments that were outside the range of their professionalism. The resource responsible unit managers supported the restricted admissions in such situations by invoking diagnosis and formal, administrative rules as objective reasons to justify denied admittance. The unit managers implicitly prioritized their budgets before patients, and the professionals' prioritized patients and treatments methods in order to foster professionalism. Consequently, we conclude that the MPT may provide patient care in a resource-effective and a professional way. However, there are difficulties in achieving individual and holistic care.

The MPT in some important and typical situations aligns the two primary logics in a search for rationality in a way foreseen by Larson (1977) who states that since both management and the professions share the ideal of rationality, they both support rational administration. But since the effect of the MPT is a smoother way of adopting NPM, the MPT concept has "NPM effects" instead of "post-NPM effects". Consequently, the MPT rebalances the NPM system rather than transforms it (see Gregory, 2006; Halligan, 2006). While the primary logics are preserved, the intended new unified values are not institutionalized. That is, in a cultural perspective (Ling, 2002), the reform is not a post-NPM reform.

Teamwork in this healthcare setting is not a marginal matter or a problematic issue as is frequently reported in the research (Payne 2000). Nor do the actors perceive teamwork as difficult, as Larkin and Callaghan (2005) report. A theoretical implication is that the negative effect of NPM on the professionals' autonomy, as reported by Tummers et al. (2009), may have been mitigated by the concept of the MPT. The MPT concept and the NPM context may both have contributed to improving the team collaboration. The well-documented gap between administration and professionals in healthcare (Øvretveit, 1993; Blomgren, 1999; Levay, 2003) may to some extent have been bridged. In fact, the results of this study challenge the importance of shared visions, good communications and role-valuing as prerequisites for successful teamwork (Poulton & West, 1993; Onyett et al., 1996; Freeman et al., 2000). Earlier studies may have underestimated the importance of "hard facts" introduced by a strong control regime, in this case, the NPM context. The control regime may take over and create collaboration; nonetheless, the outcome may not be entirely the desired one.

It is concerning and somewhat puzzling that the diagnosis of mental illness in children and adolescents is not always strong enough to make the MPT offer individual and holistic care. The reason may be that the collaboration in the CAP units aims at compliance with their restrictions, even at the expense of their mission. It may be that individualistic and holistic care is neither measurable/quantifiable as required by the resource-effectiveness goal nor focused as a consequence of the logic of professionalism. Practical implications of this study may be its focus on the importance of reducing upper management's emphasis on measuring and quantifying resource-effectiveness and its recognition that individual and holistic care is as strong (or stronger) as the quantified measures. At minimum the study challenges whether the psychiatrists' increased accounta-

bility for patient security is a realistic way to achieve individual and holistic care.

The findings of this study indicate that more research is needed on the mixture of shared visions, good communications, role-valuing and quantified measurements in MPTs. Are efficient resource utilization and individual, holistic care compatible in MPTs?

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