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AUTHORS	Tommy Jensen Ulrica Nylén

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Striving for Spontaneity – Bureaucracy Strikes Back

Tommy Jensen, Ulrica Nylén

Abstract

This paper investigates the intertwined relationship between order (bureaucracy) and spontaneity (through the organisational modes of competition and co-operation respectively). The purpose is to explore what happens when spontaneity attempts are confronted to the bureaucratic order, and why is this? The empirical setting is the public sector, which seems to be an exceptionally suitable environment to investigate spontaneity attempts in bureaucratic orders. More specifically, the article rests upon two qualitative case studies from Sweden, one in the County Council of Stockholm (were competition was introduced in health care) and one in the county of Västerbotten (where interagency co-operation was aimed for in health care and social service). From the theoretical notion that competition and co-operation share an underlying assumption of spontaneity, we empirically identify two bureaucratic forces replying to spontaneity attempts, corresponding to "what happens" in the purpose: new structures and formalised devices, which frame the re-bureaucratisation processes in both cases. A detailed analysis of the particulars of the re-bureaucratisation process, corresponding to the "why" in the purpose, reveals three underlying dimensions of re-bureaucratisation – structural bureaucracy, ontological bureaucracy and habitual re-bureaucratisation. To conclude, if organisational modes attempting at spontaneity are introduced without careful reflection, bureaucracy will strike back

Key words: spontaneity, bureaucracy, competition, co-operation, health care.
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Order and spontaneity

The organising of human interaction has been widely studied and debated throughout the history of management and organisation research. Particularly, the challenges and pitfalls connected to the coordination of social activity could be considered an eternal dilemma of balancing between on the one hand, stability and predictability, and, on the other hand, flexibility and autonomy. Actually, the very issue of organising is frequently equated with the search for stability and predictability – or, as Kallinikos (2004:26) puts it: *"Standardisation is essential to all non-haphazard human action"*, i.e. all formal organisations exhibit some form of standardisation. Simultaneously, however, a certain amount of flexibility and readiness to transform the routines of social activity and adapt to changing circumstances could be considered an equally crucial aspect of organisational life (Osborne & Gaebler, 1992). In contemporary organisational research, this dilemma is every so often discussed as a choice between the bureaucratic and alternative organisational modes (e.g. Courpasson & Reed, 2004).

Originally, the bureaucracy was considered a guarantor for reliable, non-personalised human behaviour being coordinated towards the overarching organisational goal in a hierarchical authority structure (Weber, 1922/1947). The basic organising principle might here be expressed as *order*. The bureaucracy, both as ideal type and practice, has even been considered *the* organisational form of modernity (Bauman, 2001; Kallinikos, 2004). However, the founding ideals of the bureaucracy have been criticised based on the claim that in a complex and disordered world, the ordered ideal of bureaucracy has become outdated (Osborne & Gaebler, 1992, Heckscher & Donnellon, 1994). The role-bound or ordered behaviour, which constitutes the essence of the bureaucracy, has been argued to produce routinisation, non-adaptability, and rigidity in human action and interaction. The words of Law and Mol (2002) could be used to summarise this widespread and persistent critique: it takes complexity to organise complexities.

Instead, a number of alternative modes of organising for the coordination of human interaction have been suggested, such as the market, the network, entrepreneurial government, virtual organisation, or project management (Ekstedt et al, 1999; Thompson et al, 1991; du Gay, 2004 Hodgson, 2004).

In one way or another, these conceptualisations attempt to provide new solutions to the dilemma of balancing control and stability with autonomy and flexibility. Heckscher (1994) actually provides us with a whole set of characteristics of the so-called "post-bureaucracy", such as authority originating from personal qualities instead of formal position, flexible decision making processes and readiness to change, and of open organisational boundaries. According to this view, organising is really about capturing an organisational "reality" where flux, discontinuous events, and disorder are normal, whereas stability and order are rare (Tsoukas & Chia, 2002; Law, 1994). In sum, we argue that the basic principle of order here is expected to give in to another founding principle, namely the principle of *spontaneity.* The (hitherto unarticulated) issue of order versus spontaneity is of main concern in this article.

Due to the lack of theoretical definitions of spontaneity, the concept is here used in its everyday definition (as expressed by the Swedish Academy) as impulsive actions, derived from the inner improvised will of actors, rather than from deliberate planning or exogenous forces. Applied in an organisational setting, the concept of spontaneity suggests that human action is non-manipulated, non-hierarchical, and self-regulated. Evidently, there is a natural conflict between this kind of flexibility and renewal and organising resting upon bureaucratic principles. Therefore, formal organisations in both the business and public sector frequently attempt at introducing alternative organisational forms, this, however, as du Gay (2004) among others has noticed, rarely means that one "organising logic" (the bureaucracy) is completely replaced by another. Consequently, it seems more reasonable to expect "spontaneity attempts" within the existing bureaucratic structures than a complete change of organising mode. Attempts at introducing spontaneity might take the form of reducing hierarchical levels, encouraging empowerment processes and changing managerial and leadership styles – still within the overall realm of bureaucracy. This observation implies a mutually existing and intertwined relationship between order (bureaucracy) and spontaneity (whatever the specific form of the organisational alternative) and the purpose of this paper is hence to explore *what happens when spontaneity attempts are confronted to the bureaucratic order, and why is this?*

The underlying assumption of spontaneity in competition and co-operation

Now that we have sketched out the motif for this article, we need an empirical setting in which the bureaucratic order is intended to be departed from by means of particular spontaneity attempts. The public sector appears to be an exceptionally suitable environment to look for such attempts of spontaneity. This sector, and especially certain parts of it like health care and social service, consists of large, complex organisations where professional, administrative, and political perspectives intersect (Ekstedt et al, 1999; Light, 2000). These characteristics imply that centralised political and administrative control is attempted at within a highly professionalized setting, a setting that, furthermore, has strong internal hierarchies among different professional groups (Hugman, 1991; Light, 2000). Furthermore, rapid technological and medical achievements, in combination with an aging population structure throughout most of the Western World and increased expectancies on good health and quality of life among the citizens, continuously raise the scope for public health care and social services at the same time as financial resources are becoming more and more scarce (Enthoven, 1993; Light, 2000; Saltman & von Otter, 1992). In this context, the empirical dominance of bureaucratic organisational forms is often presented as problematic (Osborne & Gaebler, 1992). Consequently, the health care and social service sector has been characterised by a continuous search for and implementation of new and better tools for management. In this context, *competition* and *co-operation* have been put forward as two major alternatives for public sector management (see Jensen, 2004, and Lindqvist & Nylén, 2002).

By introducing healthy competition and private alternatives, in the health care and social service sector, increased quality in care, dynamic innovate climate and a reduction of the overall costs is expected to be the reward (Enthoven & Singer, 2000; Light, 1995, 2000; Saltman & von Otter, 1992). Co-operation between organisations and professions, on the other hand, has been put forward as a reaction to the "New Public Management-trend" of competition and privatisation (Himmelman, 1996, Øvretveit, 1992). Co-operation is assumed to increase integration among cur-

rently fragmented, separated and sub-optimising health care providers, which will increase quality and efficiency by creating synergy in the care taking of the patient, reduce double work and encourage renewal (Hvinden, 1994; Finn, 1996; Milward & Provan, 2003). The competitive and the co-operative organisational models are generally viewed as separate forms of human interaction, not only when applied in practice but also within conventional theory on competition and co-operation. Next, we will probe into and raise doubts on this assumed theoretical separation.

According to the model of competition, actors interact independently and impersonally on a market. The only information needed to perform transactions is, on the neoclassical market, the price (Bradach & Eccles, 1991) or, on the Schumpeterian market, discrepancies in pricing (Schumpeter, 1950). Setting aside the conflict between the former and the latter view on competition as being either static or dynamic, the human nature is in both camps reduced to Homo Economicus, i.e. economically rational individuals that seek to maximize profits. Furthermore, competition is considered the primus motor in society (Schumpeter, 1950; Kirzner, 1973) and the competitive interaction and pressures steaming from competition stimulate firms, organisations, and people to maximise the effort needed to succeed on the market. Hence competition is considered a necessity to insure that efficiency and growth is attained (Barney & Ouchi, 1986; Thompson et. al., 1991), and when competition is 'healthy', society's recourses is most effectively handled and thus the public welfare is at its highest (von Hayek, 1948; Hill & Deeds, 1996). On the other hand, the management model of co-operation implies voluntary interaction between equal parties in order to reach common goals. Co-operation, therefore, rests on assumptions of similar values and mutual trust among the co-operating actors. Furthermore, co-operation requires lateral communication as contrasted to the bureaucratic chain of command. Ouchi (1980) refers to this type of organisation as a "clan" where common agreement and socialisation processes are important. In an economic context, co-operation could provide a value-adding relationship where each part contributes their specific competencies and resources to the overall process (Johnston & Lawrence, 1991). Service integration across organisational boundaries is hence expected to increase societal effectiveness.

Consequently, the conventional body of knowledge on competition and co-operation pays tribute to the distinguishing features of these ideal models regarding the intentions and motives of actors (self interest versus mutual interest) and the nature of human interaction (being characterised by conflict versus harmony). Another line of argument, within the conventional body, claims that when ideal forms of organising are applied in practice, numerous deviations will arise. To begin with, the neo-classical theory of competition has been criticised for the reason that when human individuals and collectives are in competitive interaction with each other, social concerns of political, bureaucratic and professional nature will inevitably arise. These concerns will lead to side effects and deviations from the pure form, not taken into consideration by neoclassical theory of competition (e.g. Grandori, 1997; Light, 1995; Jensen, 2004). Likewise, empirical studies suggest that co-operation is not a one and only model, rather, it could be manifested in a number of ways, and also develop and change over time (Provan & Milward, 1995; Hvinden, 1994; Gray, 1996; Batterham et al, 2002). The multitude of empirical expressions can bee seen as a mixture of co-operative and competitive relationships, i.e. business firms are frequently engaged in competition and co-operation simultaneously – co-opetition (Bengtsson & Kock, 1999). A similar observation has been made by Light (2001) in health care and the example of competitive bidding, which produces distrust at the same time as it, to be successful, rests on trust as well.

As a consequence, there is not only one competitive or co-operative practice, rather infinite variations, due to human action and interaction, will develop over time (Callon, 1998). Still, both lines within conventional body of knowledge neglect a major issue, namely the notion of order versus spontaneity when coordinating human interaction. Therefore, we will turn our attention to an analysis of this issue – what are the underlying assumptions on order and spontaneity in competition and co-operation, respectively?

According to ideals of neoclassical competition, the allocation of resources is most efficiently distributed if the market itself is allowed to govern all actions and transactions. As a prerequisite, markets, therefore, must be characterised by multiple, independent and anonymous buyers and sellers that interact with each other without any superior body controlling their interaction.

In this spontaneous competitive process, organisations that cannot manage constant renewal are outperformed. Thus, the market is considered a self-regulating system, a spontaneous dynamic order (Hill & Deeds, 1996; von Hayek, 1948). Turning to co-operation, this model is in its ideal form supposedly based on assumptions of non-hierarchical power relations and organic organising (or "loose coupling", see Chu, 1995). This ideal form entails local autonomy and grass-root level commitment that will stimulate flexible interaction, well adapted to specific tasks (Himmelman, 1996). This organisational form could be equally applied on organisations, units, or professional groups, but it is in all cases based on a belief that mutuality, trust, and long-term relationships are essential for this type of coordination to take place (e.g. White, 1974). The importance of voluntary participation as well as interaction on an individual level has been emphasised by for example Sink (1996), Bottom et al (2002) and Hill & Lynn (2003), which implies that co-operation could not be accomplished through the directives or regulations of a central authority. Moreover, it could not be formally structured and planned; instead, spontaneous interactions are expected.

A twist of the tale of competition and co-operation is that the conventional body of knowledge takes the underlying assumption of spontaneity for granted, i.e. non-hierarchical relations, self-regulation, and renewal. This, as we claim, unnoticed theoretical foundation of spontaneity is a key-issue for distinguishing between, on the one hand, bureaucracy and, on the other hand, competition and co-operation as alternative modes for the coordination of human action. Introducing management models of competition and co-operation within bureaucratic structures could therefore be considered as attempting to supplement order with spontaneity. Hence, we argue for an analysis of spontaneity attempts following from applying forms of competition and co-operation, respectively, in bureaucratic structures within the health care and social service sector.

Attempts of spontaneity

To illustrate what happens with spontaneity when competition and co-operation are implemented in the health care and social service sector, we use two empirical process studies from Sweden. One study focuses on competition in the County Council of Stockholm, and the other on co-operation in health care and social service in the county of Västerbotten. Each study was carried out by one author respectively and had a duration of three to four years (Jensen, 2004, Lindqvist & Nylén, 2002). Originally, the studies were set up independently, with different theoretical and methodological perspectives, but we recognised in retrospect the unifying issue of spontaneity and the opportunity to use the studies for an exploration of this topic.

During the time under study, the methods used to follow the processes of the respective cases were interviews, surveys, and documentary data. The empirical material is presented in the following sections on spontaneity attempts. Thereafter, we turn to the analysis of these cases. This analysis will be two-fold; firstly, we interpret the overall developments connected to the spontaneity attempts as such, thereby identifying some major mechanisms related to the question of *what happens* when spontaneity is attempted at within these empirical contexts. Secondly, we focus upon and highlight two particular spontaneity attempts, one from each case under study, in order to investigate the processes in depth and create insights into the issue of *why* this happened to spontaneity, i.e. the underlying dimensions of the process.

Spontaneity attempts and the case of co-operation

Västerbotten is a county in the north of Sweden where the County Council and the Association of Local Authorities in the late nineties made an agreement to launch a joint development work. The ambition was to improve mutual co-operation in order to improve quality and cost-effectiveness in a severe economic situation for both initiators. This agreement was in line with more general ideas of applying co-operative forms of organising in order to improve the quality of care and services without increasing costs, ideas that were nationally (and internationally) widespread at that time. This particular development work was carried out between January 1999 and December 2001 within five districts (communities or community areas), and the new work methods should then be implemented throughout the county. In each district, project leaders were appointed to manage the development work assisted by an executive group of managers from the two

principals and guided by a political steering group. A number of project groups, representing various professionals and administrators from the local welfare agencies, conducted the actual integration work.

So in the beginning of 1999, the project leaders appointed on each project area eagerly took on their assignments, however quite various approaches to the development work were taken in the particular districts. This variety was actually in line with the overall plans, since the idea was not to create identical solutions but rather to develop co-operative work methods according to local demands and ideas. The involvement of grass-root level employees and local citizens was thus considered fundamental in order to create substantial and lasting co-operation practices. However, project leaders soon learnt that they had to put in considerable effort not only in encouraging and coordinating the activities of the work groups, but also in gaining support from the regular administrative and political system of the two principals. Notably, the grass-root employees of project groups and the politicians were often the most enthusiastic about the co-operation work, whereas the managers of the welfare agencies sometimes were more concerned about the specific objectives and financial resources of their respective organisation. Concerns on whether the co-operation work would imply additional costs to one's budget, and fears of other agencies off-loading duties without compensation, hampered the implementation of several co-operative ideas.

One illustration of this clash between lateral co-operation over organisational boundaries and internal authority structures was the fate that met the plans to open a joint centre for community services at one of the districts. Initially, several agencies – like the social service, the social insurance office, the employment agency, and others – supported the idea to facilitate citizens' contacts with public agencies. As time went by it became evidently clear, however, that no single authority wanted to assume the risky leading role for the idea's implementation, and so no centre was opened during the development period. Actually, there were parallel incidents with severe co-operation project problems or failures in all districts. Local managers and professionals were on the one hand encouraged to initiate co-operation over organisational and professional boundaries, but, on the other hand, whenever such initiatives required additional funding or internal reorganisation, difficulties arose. It was hard to integrate cross-sectional activities into the formalised plans of the involved organisations. Internal decision-making procedures became especially slow when non-traditional issues were processed. During the development period, experience showed that organisation specific budgetary considerations and authority structures severely hampered the political ideals of local integration in Västerbotten.

However, some co-operation attempts did make lasting imprints on the local welfare system. One general integration problem concerns communication between municipal home-help services and primary care when engaging in the care taking of elderly people in their own homes. If both agencies coordinate their efforts, it was argued, quality in care could increase, and double work reduced. At one district, home-help personnel wished to be able to reach districts nurses on a flexible basis. The project group therefore set up a number of routines for their interaction, for example fixed telephone hours and regular meetings, hence providing a platform form spontaneous communication. This joint platform, however, required a change in the division of nurses' work at the primary health care centre, which in turn impaired upon nurses' internal communication with doctors.

A similar coordination problem triggering spontaneity attempts has do to with communication between care providers at hospital discharge, where the responsibility for the patient is transferred from the hospital to primary care and municipal elderly care. In many cases, professionals then feel a need to meet and discuss the patient in order to create an unbroken chain of care, but such meetings are often difficult to arrange in practice due to differences in internal work routines. Formal procedures for joint discharge planning were hence developed at several project areas in order to facilitate this type of co-operation, stating who should be contacted, when and how, and the type of information to be exchanged. These procedures substantially improved communication between the parties.

In some instances, the development work rather took up existing co-operation practices, either simply incorporating them as they were, or with some refinements or extension. For instance, a well functioning informal collaboration had developed over the years at one district be-

tween the social service, the school, the police, and others, regarding young people in the area. This collaboration had been successful in preventing socially deviant behaviour among young people. When the development work was launched, a formally established young people's team replaced this loosely structured collaboration with representatives from the social service and the school department. Following from the establishment of this team, two social workers were placed within the school building (senior level) with the ambition to integrate the social and educational perspectives on young people's health and quality of life. Even though this arrangement did support spontaneity attempts, it became evident that it also hampered the social workers' contacts with their home organisation, and so the team was eventually broken up.

Mentally disabled adults are another group of patients frequently in need of care and services from several authorities simultaneously. At one district, the communication between psychiatric care, primary care, and social service concerning these patients had been very poor for a long time. This lack of communication impaired upon the care taking of people with multiple and complicated needs. During the development project, it was decided that a formal co-operation contract should be drawn up demanding the involved parties to communicate. In this case, as in several similar ones, the initial ambitions of the development project to encourage creative solutions and grass-root level enterprises were replaced by formalised routines installed at higher organisational levels. In other cases, entirely new structures were developed in order to manage co-operation between organisations or organisational units. Multi-professional mobile teams were established at several project areas for home based medical or nursing care, home rehabilitation or palliative care. Thereby, an integration of professional views and better adaptation to patient needs was expected. Obviously, these boundary crossing, formalised co-operation arrangements required not only the commitment from the involved professionals, but also financial support granted by the managers of the respective organisations.

At the end of the development period, co-operation had improved at all districts – to various degrees and scope. Many spontaneity attempts had struck root and begun to thrive, albeit often distorted, in comparison with the initial ideas, to fit in with the bureaucratic structures of the County Council and the local authorities. Other attempts of spontaneous co-operation more or less came to nothing, as cooperative activities connection to actors' spheres of responsibility was ambiguous. One overall interpretation that the head of the County Council made was that cost-effective co-operation with local authorities requires more formalised integration approaches, and so this development work was succeed by an experiment with joint political governance and shared financial resources within a particular community in the county.

Spontaneity attempts and the case of competition

In 1998, a new political majority was elected in the County Council of Stockholm – the by far largest council in Sweden. The new right-wing majority soon presented a political program (named With Focus on Care), which largely was based on the previous political program (The Competitive Program, 1991-1994). In the political program, the right-wing majority accentuated the need for competition and a multiplicity of providers as a mean to improve the health care. Competition was, among its advocates, i.e. right-wing politicians as well as some civil servants and professionals, considered as a salvation during the regression of the Swedish economy in the early nineties. However, this time the right-wing majority was even more determined to boost the element of competition and multiplicity and to fulfil some of the earlier political intentions (1991-1994). This also proved to be the case.

As a route to introduce multiplicity and competition, a number of spontaneity attempts were initiated. Firstly, the family doctor reform was re-implemented and personnel were allowed to take over care centres, i.e. starting their own business. To assist these takeovers a so-called multiplicity office was initiated, and in order to nurture the emerging market a trade association was established. There, different parties, i.e. politicians, public and private providers and purchasers, could meet and discuss important matters. Finally, and of crucial importance here, emergency hospitals were transformed to limited companies and one of them was even privatised. The underlying reason for this transformation was to further develop the separation between the provider and the purchaser by introducing businesslike conditions in which the purchaser only analyse the needs of

the population and providers accomplish the orders. Obviously, this course of action had to correspond to the economic resources available in the County Council. The sovereignty of the emergency hospital was thus considered vital and expected outcomes of this autonomous process were; increased spontaneous and entrepreneurial activity, i.e. new solutions; economic rationality, e.g. to calculate long-term investments and to analyse production costs; and, finally, settlement of agreements concerning yearly production and prices.

The overall belief was that through the limited company actors are able and forced, by The Companies Act, to calculate long-term investments and to control the overall production costs. The expected outcome was that the limited company should keep within the limits of the budget, which the traditional publicly driven emergency-hospital was claimed not to do. Further, new and better routines in terms of organising, both within the business entity itself – the hospital – and with its external environment – co-operation with other hospitals and primary care – could be rendered possible. During this term of office all but two emergency hospitals – of a total number of seven – were transformed to limited companies and one hospital, St. Göran, was sold to a private firm, Capio Healthcare. Thus, St. Göran became the first privately owned emergency hospital in Sweden. In the written contract between Capio Healthcare and the County Council of Stockholm, it was stipulated that St. Göran could compete with the other emergency hospitals that were limited companies. A big competitive bidding (called the Big Procurement), with an expected value of 10 billion Swedish crowns (1 billion Euros), was to be launched on the 1st of January 2003.

The initial attempts (introduced 1998-2000) soon faced problems. A first critical issue was; what was to be exposed to competition – individual patients, diagnoses, clinics, hospital management, or even the sell out of complete hospitals? Could the competitive process result in the bankruptcy of a complete emergency hospital? Safety barriers were therefore implemented regulating the number of emergency hospitals, which corresponded to the number of emergency hospitals present at the time. Further regulations stated that certain clinics were considered fundamental for an emergency hospital, thus these were not to be exposed to competition. Finally, it was not considered possible to divide an emergency hospital into different types and forms of providers because different parts of an emergency hospital are so firmly integrated. Initially, thus, everything within the hospital was supposed to be exposed to competition, but this was gradually reduced. After the performed regulations, what was left that could be exposed to competition was 10% of the original 10 billion, at the most.

Another critical issue was who should establish the rules of the game? Negotiations between the purchaser and the providers, about yearly volumes and discounts, were constantly being delayed. In some cases, negotiations were not settled until the year had almost passed. The underlying problem was to establish accurate price-levels for the services. St. Göran even pulled out from the DRG system – a system that estimated the payment, i.e. the price, based on calculated costs per diagnosis as reported by the emergency hospitals. Since St. Göran was approximately 10-15 % more cost-efficient than the other hospitals, the average cost per diagnosis increased when St. Göran left the system, and the hospital could through this spontaneous action increase its margins of profit.

Another case was Huddinge University Hospital AB that lost a competitive bidding on geriatric care, but refused to close down the department in question, claiming that they needed this department in order to maintain its high-quality research. This refusal resulted in that both the winner and the looser of the competitive bidding continued their activity at full production. Therefore, negotiations between purchasers and providers, that before had been an affair between local parties, were centralised and became an affair between high ranked civil servants, top politicians and the top management of the provider itself. These described difficulties caused an increase in the number of employed civil servants and their amount of duties, for example, the main centre of purchasers, the centre of price-calculation, and the centre of contracting. Another project that was initiated was medical programs. The aim of the medical program was to create clusters of diagnoses in order to make patients more homogenous and map out different diseases. In the County Council of Stockholm, this program was seen as an opportunity to establish and develop the fundamental ingredient on the market, namely market prices.

Regarding investments, the limited companies, through its board of directors, decided what to invest and what not to invest. The County Council of Stockholm was at the time in a severe financial situation; according to the political opposition, the County Council was borrowing money to maintain the current production, and the emergency hospitals' overall strategy seemed to be to expand out of the crisis. This strategy was particularly the case with the hospitals that were transformed to limited companies. The case of Huddinge University Hospital AB is especially revealing. Huddinge utilizes the space for spontaneous action and decided to invest in its personnel, hence launching a program named The Healthy Workplace, an investment of some 80 million Swedish crowns (8 million Euros). The program aimed, among other things, at higher salaries to stop the high personnel turnover. This initiative amplified the increasing cost-spiral that was in bloom in the County Council of Stockholm. The competitive advantage for Huddinge – higher salaries – soon vanished resulting in that the overall costs increased, i.e. it became a zero-sum-game but on a new and higher level. Huddinge also decided to digitalise its radiotherapy department and to rebuild three departments – ambulance, anaesthesia, and intensive care – at a total cost of 190 million Swedish crowns (19 million Euros). From the political point of view, these investment decisions should not have been taken by the hospitals themselves. Therefore, decisions concerning investments were centralised and formalised, i.e. the hospitals had to apply for allowance to invest.

We will now move on to the analysis of our empirical stories, extracting the central issue concerning how spontaneity is gradually being altered during the process of competition and co-operation, respectively.

New structures and formalised devices creeping in

So what happened to spontaneity when confronted to the bureaucratic order in Stockholm and Västerbotten? At the outset, ideals of non-hierarchical arrangements, self-regulation, and renewal were embraced under the umbrella of competition and co-operation respectively. For example the competitive attempt of privatisation and "enterprising up" (du Gay, 2004), i.e. emergency hospitals as limited companies, business-like role bounding (purchasers and providers) and the cooperative attempt of formation of multi-agency teams and other platforms for continuous interaction.

A general reflection regarding the spontaneity attempts that we have studied is that *new structures* and *formalised devices* gradually crept in as the processes unfolded over time. In Stockholm, decision procedures were formalised as investment decisions were lifted from the limited companies up to the central level of the County Council. Price competition through tendering led to endless negotiations and, eventually, contracting was centralised. Furthermore, only a fracture of the possible competitive market was exploited after several formalised devices in the distinctive shape of regulations had been implemented. New structures were also created to stimulate spontaneity attempts such as a trade association and a multiplicity office. Furthermore, and parallel to these processes, existing structures expanded heavily in order to handle the price system, contracts and competitive bidding (especially notable amongst the ranks of civil servants that were involved in the medical program, the construction of the Big Procurement, and the tasks of constructing and negotiating contracts).

In Västerbotten, it soon became evident that introducing co-operation frequently resulted in the establishment of formalised devices. For instance, the actors considered specific routines and agreements necessary for joint planning at hospital discharge. Furthermore, a contract was written stating how primary care, psychiatric care, and social service should co-operate regarding mentally disabled adults. Formalised devices were also implemented in order to standardise interaction between primary care and home help services. In other instances, failure to come up with formal agreements hindered the co-operation attempts. A number of different types and forms of structures were also created to facilitate spontaneous interactions, such as multi-professional teams, which usually required top level political and management support in order to allocate resources and make the formal decision to start up the team. Therefore, some co-operation initiatives

could not be implemented due to lack of such support, which meant that grass-root level spontaneity was effectively hindered by the bureaucratic structures.

The stories of Stockholm and Västerbotten differ to some extent in that the competitive attempts were considered to be *too spontaneous* (for example the hospitals urge for market expansion), whereas the co-operative attempts were *not allowed* being spontaneous (they were caught in the bureaucratic structures). In this sense there were more immediate and severe complexities arising in the competitive context, i.e. unintended side effects. These differences, between the empirical stories, are not, however, outcomes due to that competition and co-operative management models foster unique and distinct patterns of human behaviour. The differences observed are not possible to generalise in this matter. Rather, a general reflection is that, as Mol (1999) tells us, organising is a heterogeneous process in which multiple worlds are created, and therefore there are numerous different strategies and different styles. Sometimes they end up in harmony, and some time they do not (Law, 2002).

To conclude, the response to the spontaneous ideal of competition and co-operation was the creation of formalised devices and new structures – as well as the expansion of old structures – and, finally, centralised decision-making. *Why did this happen then* is the question that we will pursue with by zooming in on two specific examples from competition and co-operation respectively, that of competitive bidding and young people's team. By analysing the particulars of these spontaneity attempts and the reactions on these, we aim to show the underlying dimensions of the re-bureaucratisation processes.

The re-bureaucratisation process of Young people's team

An interdisciplinary team of social workers, a school nurse, a school welfare officer, special pedagogues and youth recreation leaders developed as an extension from an existing, informal collaboration among the social service, the senior level school, the police and others regarding young people with socially deviant behaviour. The ambition with the formation of the team was to intensify collaboration between two of the involved agencies, namely the school and the social service, hence reducing problems of drug abuse, juvenile crime, truancy etc. in the district. This team was considered a flagship of collaborative effort, or, as the school headmaster put it when asked about positive collaboration experiences in the local context:

"This [young people's] team is absolutely a very good proof of collaboration."

The now formally established team continued to formulate and implement many ideas for improved welfare among young people in the area, for instance joint plans of action in case of crime, violence and other emergencies, and individualised social support to vulnerable young people. The true novelty with the team was not, however, the activities per se, even though these did involve more far-reaching engagement on behalf of the two parties; instead, the team formation was accompanied with some relocation of personnel and activities. For one thing, the youth recreation centre was moved from its present premises in the public centre building to the senior school building with the intention to integrate school and leisure arrangements. Secondly, and most important here, two social workers changed their place of work and went from the local social services office to the school building with the assignment to work full-time with people aged 10-16. Since they were still employed by their original agency, issues of leadership and formal authority soon appeared. The team was very informally managed and lead, which had the effect that social workers were not formally introduced to the teaching-staff and integration was hence limited. In addition, social workers did not possess the discretion to make decisions on their own; instead, they frequently had to check proposed plans and activities with their home organisations. From the point of view of their home organisations, the relocation of two staff members was not fully appreciated by all:

"Our [the social allowances section's] collaboration with the social welfare section has become more difficult since two social welfare secretaries are not physically in the same building any more." (Group-leader in the social services agency)

From the point of view of the responsible project manager, these issues were considered as temporary problems during the running in period. During a conversation with the researcher

some 1,5 years after the team's establishment, the project manager assured the researcher that *"it was some leadership confusion initially but now it has improved"*. From the point of view of team members, the physical proximity was considered a substantial advantage in facilitating spontaneous interaction on a day-to-day basis and jointly developing integrated educational and social solutions for young people.

Nevertheless, the dual habitat of social workers eventually became too frustrating for themselves and their co-workers. They claimed to miss their daily interaction with co-workers and their team-mates from the school complained about them not being able to make decisions; *"they must always ask [their home organisation] first"*. The social workers gradually and quietly reduced the time spent in their school offices and finally moved out entirely. This moving out was considered the end for the young people's team in its original design; however it still worked as a foundation for future collaboration among the parties.

The choice of teamwork design for collaboration around young people's health and well-being could hence be considered an effort to formalise an existing, informal interaction among organisational actors. To provide a working platform for spontaneous collaboration, *order* in the form of a new structure for coordinating action was imposed. Initially, this orderliness also provided fruitful for concrete activities in line with the spontaneity ideal, however the tension between the teamwork organisation and the home organisations gradually increased. When uncertainties arise, actors looked for guidelines on decision-making and leadership without finding them within the team organisation, i.e. the spontaneous coordination of human action did not provide the standard bureaucratic tools. Therefore, when interdisciplinary, horizontal communication collided with bureaucratic lines of authority, the former coordination logic had to "give in" for the latter. On an individual level, actors tended to provide personal and situational explanations for this line of development, not seeing the inherent conflict between the order of the teamwork and the order of the bureaucracy.

The re-bureaucratisation process of Competitive Bidding

An underlying assumption with procurement under competition was that the involved hospitals (private and public), as a consequence of this contestable competition, must improve their production, and initiate new ideas and strategies. This procurement under competition was founded on price and quality to determine hospitals' market-shares. The following quotation from one right-wing politician illuminates possible consequences:

> *"When we perform the procurement under competition and we observe that St. Göran's price is 22000 per DRG-point and that Huddinge wants 25000. Then we will of course see to that St. Göran receives more patients and Huddinge less (...) but we have to implement some barriers in this procurement under competition, because we cannot replace the whole of Huddinge, at least not in the short-term. It will be a step-by-step change where St. Göran is allowed to expand and Huddinge has to reduce [its business]."*

The market was accordingly sectioned to avoid the rise of monopolies and to split-up existing ones, and barriers to exit were created (for example, the numbers of hospitals still had to be seven and some clinics were defined as mandatory for an emergency hospital). A similar regulation was that no hospital was to be divided into different sections with different responsible actors. A fundamental tool used to manage the procurement process was contracting in which rule-bound behaviour and business-like relations could be established. A number of contracts between purchasers and providers were hence established, but not long after problems occurred. Different parties interpreted the contracts differently (for example regarding volumes, price, and discounts). One civil servant related this problem to the use of old standardised techniques for writing contracts, and told this story:

> *"Last week I was at a meeting with the managing body of the healthcare committee, that is the managers of the healthcare-regions [within The County Council of Stockholm], and I said to them that the written contract that exists with X (...) comprises of annexes with DRG-points and three pages of text. I often claim that this must be the shortest agreement in history embracing 2,5 million (250 000 Euros)."*

These interpretation problems resulted in "endless" negotiations between contracting parties, followed by the re-writing of contracts, and by each part bringing in lawyers and experts. The procurement process thus turned into a detailed scrutiny of paragraphs instead of the ambitious vision to improve production and implement new ideas and strategies into the County Council of Stockholm. Furthermore, contracting and negotiations gradually became an affair between officials with formal authority from each part, thus triggering a centralisation process.

The ambition of the competitive bidding was that written contracts and the price-mechanism should provide a platform for spontaneity attempts. Initially, the competitive bidding proved to be a success, if judged by the very definition of the word of spontaneity. The providers exploited this platform for offensive strategies and market expansion. However, the actors within the line of authority were threatened by these spontaneity attempts as they assumed that it would trigger even higher costs. The tension between providers, within the autonomous foundation of the limited company and purchasers were intensified, and to some extent became infected due to increasing uncertainties on who was to decide upon what, and when. So the encouraging of spontaneity attempts turned out to have unintended side effects, triggering an attempt on behalf of the initiating actors to restore order and manage competition through new structures and formalised devices, i.e. a habitual reach for regulation.

Bureaucracy strikes back!

The intertwined relationship between order, manifested by the bureaucratic organisational mode, and spontaneity, through the pursuit of alternative organisational modes, has been the subject for this article. In particular, we have investigated what happens when spontaneity attempts in the shape of competitive and co-operative initiatives are confronted to existing bureaucracies within the health care and social service sector. Our analysis of the two empirical cases has revealed that, as the process of competition and co-operation unfolds, the unpredictability and vulnerability that follows from the spontaneous order will create a need to stabilise and control the relationships. Spontaneity – whatever management model – seems to create disorder and discontinuity which is very hard for actors to cope with. Attempts at introducing renewal, non-hierarchy, and self-regulation thus seem to have an inherent tendency to be countered by new structures and formalised devices, as shown in the preceding section. This inherent tendency is perhaps not a new insight, rather, similar reverse processes and stagnation tendencies have previously been acknowledged in social science research (e.g. on decision making: Cyert & March, 1963; on innovations within bureaucratised structures: Kanter, 1983; on cultural patterns: Schein, 1992). So the answer to the question of *what happens* when spontaneity attempts are confronted to the bureaucratic order might be concisely framed as: increased formalisation, centralisation and, overall, a re-bureaucratisation process involving new structures and formalised devices that circumscribe and blur the spontaneity attempts.

The crucial question here then is *why* these re-bureaucratisation processes emerge as replies to spontaneity attempts. Through zooming in on two examples within competition and co-operation, respectively, we have attempted at opening up the black box of re-bureaucratisation. This pursuit is, in some sense, an attempt of establishing what is going on "out-there", but not with the intention to identify causes and effects. Rather, order and spontaneity are embedded processes in much the same manner as Law's (2002) statement that culture is economy and economy is culture. From the viewpoint of spontaneity and its embeddedness with order, we argue that this tendency of re-bureaucratisation has underlying dimensions evident only when theoretical issue of spontaneity is addressed. From the zooming-in-analysis, we have identified two major dimensions of this re-bureaucratisation process, which we will call *structural bureaucracy* and *habitual re-bureaucratisation*.

Firstly, structural bureaucracy implies that spontaneity is attempted at within a bureaucratic structure, i.e. the competing or co-operating parties are still bureaucracies in themselves (cf. Schofield, 2001). Self-regulation and grass-root level commitment, even though often being vital for well functioning interaction in both cases, is not enough to implement new forms of human coordination. As was shown in the empirical stories, support from the top political or managerial

levels was indispensable (e.g. when guaranteeing St. Göran a competitive position or to decide on a new, multi-professional team for interdisciplinary interaction in Västerbotten). Furthermore, formalisation can overcome limitations concerning incompatible goals and authority systems between the County Council and the local authorities, as well as physical and/or cultural distances. Overall, these examples illustrate how spontaneity attempts are constantly accompanied with existing structures of bureaucracy.

Secondly – and what we suggest is our main empirical finding – this re-bureaucratisation is executed with a habitual, non-reflexive and naïve use of the traditional bureaucratic toolbox – a habitual re-bureaucratisation. When problems, conflicts, or uncertainties arise during the competitive or co-operative practices, the actors habitually reach for organisational solutions inseparable from bureaucracy with the intention to restore order. For instance, who should actually decide what and when to invest; the owner, the County Council, with its perspective and professional experts, or the limited company with its independent board of directors and its professional experts, and, finally, which part should actually finance the investment? Moreover, when a social worker is placed in the school building in order to co-operate with school personnel, should s/he primarily be engaged in school matters or with the implementation of the Social Services Act? When uncertainties such as these arise, actors unreflectively look for standardized solutions from the bureaucratic mode of organising, such as detailed regulations, centralised decision-making and reinforced structures.

Confronted to uncertainties and disorder, solutions prompted for were those of re-bureaucratisation, but these uncertainties and disorders constantly escape order. Sometimes this habitual reach was a success, but sometimes instead caused severe side effects. What is striking is that despite the presence of structural bureaucracy and the introduction of habitual re-bureaucratisation processes, the actors still firmly believe that the ideal of spontaneity could be preserved. Following Schein (1992), there are certain assumptions that are so deeply rooted in human thinking that we are unaware of them (for instance chronological time). Deeply rooted ontological assumptions could be considered a "natural" explanation of the human motif – human nature fears uncertainties and pluralism and cherishes certainty and predictability (Law, 1994). There is hence a basic need for human beings to create order when coordinating human action. Actually, this ontological need might be especially strong in a bureaucratic structure (Gouldner, 1954). Therefore, we wish to add a third dimension of the re-bureaucratisation process, namely *ontological bureaucracy*.

Whether this assumption of ontological bureaucracy still is relevant and thus an effective way of taking care of disorder (here recognised as spontaneity attempts) is heavily debated. What if this strive for ontological clarity is, in it self, a huge source for disorder (c.f. Beck, 1992, 2003) because of the present time of unrest and upheaval where post-modern conditions counters modern (c.f. Bauman, 2001)? This debate is really out of reach for this article, however we do wish to emphasise that, as Kallinikos (2004) argues, bureaucracy proves a remarkably capacity to adapt to turbulence and disorder.

Our main line of argument is that ontological bureaucracy is deeply rooted in human consciousness and as such is almost impossible to alter. However, this rigidity seems to be the case for structural bureaucracy also, in that bureaucracy is the very foundation of organising and therefore is not so easily discarded. Therefore, ontological and structural bureaucracy seems to be an inevitable part of contemporary organisations, as illustrated in the cases, hence not possible to alter by limited spontaneity attempts. Still it should be possible to reflect upon the bureaucratic forces that will follow any attempt of spontaneity. Nevertheless, unlike ontological and structural bureaucracy, we argue that habitual re-bureaucratisation is not inevitable – on the contrary: habits could be broken off! The main challenge, therefore, is to maintain the idea of spontaneity without habitually and naïvely creating new structures and formalised devices when uncertainty and disorder arise. What we suggest, and raise concern of, is that those who manage complex organizations must question the naïve use of the bureaucratic toolbox, to at least avoid habitual creation and constructions of unintended (often severe) side effects. The conclusion made is that spontaneity triggers bureaucratic countermoves, and that it is therefore of utmost importance to acknowledge the foreseeable counter movement of habitual re-bureaucratisation.

The main theoretical contribution of this article is that spontaneity – in whatever organisational mode – cannot maintain its original, pure form other than temporary. Therefore, spontaneity – much like democracy – seems to be an ideal that constantly must be won and won back. If organisational modes attempting at spontaneity are introduced without careful reflection, bureaucracy will strike back.

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