Meta-organizational Consensus –
A case study of decision-making in a meta-organization in Swedish healthcare

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Foreword and Acknowledgements

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Abstract

Purpose – In the context of digitalization in healthcare and Swedish demographical development, the importance of meta-organizational decision-making can be discussed. This paper studies the decision-making processes in a national meta-organization which members face the current challenges of Swedish public healthcare. Therefore, this paper aims to contribute to meta-organizational decision-making.

Design/methodology/approach – This paper has a qualitative approach and is based in abductive reasoning towards theory and research. Data has been collected from interviews, podcasts and documents that describe the decision-making process in the meta-organization.

Findings – Our empirical findings show that the decision-making process of the meta-organization is complex, time-consuming and aims to provide consensus before its members’ decisions. To reach consensus, the meta-organization uses various coordination and collaboration activities and groupings such as networks, workshops, expert panels, and conferences.

Practical implications – Both informal and formal activities and groupings are considered important in reaching consensus. Furthermore, both formal and informal groupings help to overcome interest-conflicts such as differing priorities. It is also important the meta-organization provide an arena where all members feel that the can contribute and influence the decision-making process, regardless of size or resources.

Originality/value – Because of dichotomic views on the importance of consensus in decision-making in meta-organization, and from calls for future research, this study can be argued to be of interest. Furthermore, digitalization and demographical development suggest that the healthcare sector is in current and significant change.

Keywords – decision-making, meta-organizations, digitalization, demographics, healthcare, coordination, interest-conflict, consensus

Paper type – Research paper, master’s thesis
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I Introduction

Digitalization in general can be compared to revolutions, such as the industrialization in the 1800s, which ultimately changed the whole society and took organizations to completely different levels. From an organizational perspective of digitalization, it can be described as force for change and to provide possibilities to increase effectiveness by digital technological developments. Furthermore, digitalization is described as to change the way we live and how organizations go about their business and organize themselves. Digitalization then can be argued to be a matter of interest for any organization. One type of organization is so-called meta-organizations, which is an organization that is theoretically defined as where the members are other organizations, in comparison to other organizations whose members are individuals (Ahrne and Brunsson, 2005). This paper presents our study of such a meta-organization that are active in the Swedish public healthcare sector, reviewing its decision-making processes such as collaboration, cooperation and consensus-building. This is conducted in the context of digitalization and changing demographics in the Swedish public healthcare. It’s an interesting area of research since we have this rapid force of digitalization that’s challenging the healthcare industry, in a sector such as the healthcare sector which is characterized as conservative in the sense of thoroughly testing before implementing. This along with demographical changes of an increasing population of elders in Sweden (Ippolito et al., 2016; SCB, 2018), boils down to a combination of how a meta-organization is tackling this and how the meta-organization go about their decision-making processes. All this considered, this is an intriguing area to research both from a practical and theoretical perspective.

1.1 Problematization

The public healthcare market in Sweden is facing demographic changes of an increasing larger population of elders (Ippolito et al., 2016; SCB, 2018), which is commonly described as in greater need of care, and more complex care, because this group tend to be multi-ill (Läkartidningen 2010; Anell, Glenngard and Merkur, 2012, p. 96). Also, the Swedish public healthcare costs are increasing and especially costs related to group of elders (SCB, 2016). This demographic development also means that we have an increased elderly population that must be supported financially by a relatively smaller work-force. Since the Swedish healthcare is primarily publicly funded, how to solve or mitigate these costs problems and increase efficiency has been discussed frequently in the political debates and by interest organizations.
In the context of changing demographics, the need for efficiency in the healthcare can’t be emphasized enough.

Furthermore, another trend is digitalization which is starting to get a serious foothold in the Swedish public healthcare market (E-hälsa, 2016), and since Sweden has a great technological infrastructure (Business Sweden, 2015), the conditions for digitalization in the healthcare markets have great potential for increased efficiency (Iveroth, Fryk and Rapp, 2013). Further, according to Peppard (2016) and Kotarba (2017), digitalization could also offer several opportunities to great cost savings and to increase overall firm performance. Specifically, in healthcare, if IT is aligned with strategy and objectives it could increase quality, efficiency and patient care (Iveroth, Fryk and Rapp, 2013). However, some may fear that digitalization is not only an opportunity but also a threat to some professions and organizations (CNBC, 2017). For example, artificial intelligence is argued to replace doctors in many aspects, not all though and private, and digital, healthcare actors that exploit the possibilities with digitalization may be perceived a threat to public healthcare actors (Dagens Arena, 2017).

With these demographical changes and the contemporary phenomenon of digitalization in the Swedish healthcare, and the fact that the Swedish public healthcare is divided into 21 counties/regions (SALAR, 2018), there’s a need of tackling these trends collectively. Both the demographical development and digitalization are not geographically bounded, thus these causes common problems for all counties and local municipalities. However, the counties and local municipalities are in self-govern when it comes to providing healthcare (SALAR, 2015), which means there is a risk of great variation in quality, safety and cost-effectiveness of their operations. Therefore, there is a need to commonly face these challenges, and SALAR is such a common effort. Thus, there’s a collaboration between the 21 counties/regions and 290 municipalities in Sweden, via the Swedish Association of Local Authorities and Regions, SALAR, (SALAR, 2018). SALAR is an organization where the members aren’t individuals but organizations, which is defined as a meta-organization (Ahrne and Brunsson, 2005). One of the functions of a meta-organization is to gather these organizations under its umbrella for a collective playing ground, where decisions are made (Berkowitz, 2018). Both Ahrne and Brunsson (2008) agree with Berkowitz (2018) of making decisions by consensus in a meta-organization, and the reason of that is partly due to the structure of member’s autonomy. In contrast, Karlberg and Jacobsson (2015) argue that decisions in meta-organizations are based on a voting majority rather than consensus. Moreover, there might be frictions when making
decisions in a meta-organization, for example, Berkowihtz and Bor (2018) describe the decision-making process as sometimes problematic due to different prioritization of its members.

Furthermore, making decisions in a meta-organization can further be problematic since members of the meta-organization are accountable both to their own organization and the meta-organizations (Berkowihtz and Bor, 2018). König, Schulte and Enders (2013) further discuss this and add, because the members of the meta-organization have multi-demands the decision-making process are generally slow in a meta-organization. Gulati, Puranam and Tushman (2012) also discuss that coordination and linkages between members of a meta-organization are important in the decision making-process, for example, creating clusters between certain members. Even though there might be problematic aspects of making decisions in a meta-organization, the meta-organization provides a good platform for members in a common industry to discuss and collaborate with each other and tackling common challenges and opportunities collectively.

There are calls for further research in the field of meta-organizations, for example, Spillman (2017), Gulati, Puranam and Tushman (2012) and Berkowitz and Dumez (2016) who study meta-organizational and where one suggestion for further research is how meta-organizations interact with its members but also how they interact amongst themselves and their environments. Therefore, we decided to study meta-organizations by looking at the decision-making process in the Swedish public healthcare.

1.2 Purpose and research question

Our purpose with this study is to gain deeper insights of meta-organizational decisions-making processes in the context of digitalization and the Swedish public healthcare sector.

What do a meta-organization provide for its members in their decision-making processes and why is a meta-organization’s decision-making activities perceived as important?
1.3 Aim of study
The aim of the study has been to explore the decision-making processes in a meta-organization that operates in the context of the Swedish healthcare sector. This will provide a deeper understanding about how meta-organizations organize themselves and why it is important for its members.

1.3.1 Theoretical contribution
We believe that our main theoretical contribution would be in the field of meta-organizational research in general and more specifically decision-making processes in meta-organizations.

1.3.2 Practical importance
Our study would provide a description and an example of how decision-making processes can be designed in the context of a meta-organization.

1.4 Delimitations
From our perspective, much about decisions-making, what happens before processes and the actual decisions are not in the scope of our research. Neither do we look on cognitive biases, or suchlike, that may influence decision-making. We have limited ourselves to the study of the process in preparations before any decision is made and with an organization perspective.
2 Theoretical background

The purpose of this section is to achieve an understanding of what research that have been conducted in our theoretical field. This is done by defining what a meta-organization consist of followed by how decisions are made. Because of how meta-organizations is defined, partly as ‘organizing its environment’, we believe that context-based research about digitalization and healthcare is of importance. Lastly, we conduct a summary of the theoretical background and present our conceptualized framework for this thesis.

2.1 Organizations and Meta-Organizations

Organizations is not a new concept and there has undoubtedly been a lot a lot of studies conducted within organizational theory. Early research from Burns and Stalker (1961), Galbraith (1977) and Pugh et al., (1963), intended to understand and study collective efforts, meaning that how a collective purpose could be gained through structures and processes of organizations. Where Burns and Stalker (1961) reviewed management systems, Galbraith (1977) studied organizational design and Pugh et al., (1963) referred to organizational structure. Mintzberg (1980) further discuss designs of organizations and propose examples of what elements organizations should consider in designs of organizations which are, for example, professional bureaucracy and divisionalized form. However, in relative recent research of organizations, Ahrne and Brunsson (2005; 2008) introduces a concept of meta-organizations, which the following section will dig deeper into.

2.1.1 Meta-Organizations

According to Ahrne and Brunsson (2005) meta-organizations aren’t a new phenomenon and are more common that one might know. Today there are several forms of organizations and it’s common that one not only belong to one organization but rather of many organizations. Organizations which one may belong to could be the state, non-profit organizations, firms or larger associations such as national labor unions or international unions (Ahrne and Brunsson, 2008, p. 44). Organizations can be designed in several forms and sizes, and examples of that are global organizations such as the UN, the EU, FIFA, the WTO etc. (Berkowihtz and Bor, 2018). These organizations are often called associations, but could theoretically be defined as *meta-organizations*, which are defined as organizations where the members are organizations (Ahrne and Brunsson, 2005; 2008). Meaning that that the members of a meta-organization does not consist of individuals but rather of organizations (Ahrne and Brunsson, 2005; 2008).
Though, historically, when theorizing about organizations it has been common to define them as consisting of individuals and not organizations (Ahrne and Brunsson 2005). In contrast, Gulati, Puranam and Tushman (2012) define meta-organizations somewhat different, they don’t exclude individuals but rather consider meta-organizations to consist of organizations and/or individuals. Moreover, for these organizations-of-organizations collaborations to be meta-organizations they do not necessary need to be bounded globally or within a certain sector i.e. public, private or third sector (Berkowihtz and Bor, 2018). Gulati, Puranam and Tushman (2012) further define meta-organizations as networks which are built upon system-level objectives, and these networks consists of firms or individuals which is not bounded by any authority based on employment relationships. These collectively crafted system-based goals will help and enable the meta-organization’s actor’s commitment to act collectively (Lundrigan, Gil and Puranam, 2015); Berkowitz and Dumez, 2016).

Furthermore, these meta-organizations could be multi-partner alliances, trans-governemental networks, corporative-associative order and industrial associations (Berkowihtz and Bor, 2018). For example, a trade association can be built as a meta-organization where member organizations might pay a subscription fee, with a purpose of benefiting the industry or the society from a broad perspective (Rajwani, Lawton and Phillips, 2015).

Ahrne and Brunsson (2005; 2008) defines meta-organizations based on two elements; organizations environment and membership.

2.1.1.1 Meta-Organization’s environment and structure
One of the two fundamental pillars which the definition of a meta-organization lies on is the environment (Ahrne and Brunsson, 2005; 2008). According to Berkowihtz and Bor (2018), organizations can affect or be part of their environment by being a member of a meta-organization, for example, the meta-organization might provide the members with coordination and regulation as well as a platform for negotiation between the members. Ahrne and Brunsson (2008, pp. 49-51) refer this coordination to a decided order for the members in a meta-organization. Ahrne and Brunsson’s (2005) perspective on the environment is that the environment is generally described as hostile and uncertain, however,

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when members decide to become a part of a meta-organization they also become co-members of the same environment. Thus, this leads to a change from an environmental order to an organizational order (Ahrne and Brunsson, 2005). For example, Berkowitz and Dumez (2016) studies the oil and gas industry which consists of meta-organizations and show that by being a member of the meta-organization the members could shape their environment.

Berkowitz and Dumez (2016), Berkowihtz and Bor (2018), Ahrne and Brunsson (2005; 2008) and Berkowitz, Bucheli and Dumez (2017) all present different examples of meta-organizations; FIFA, the European Union, the United Nations etc., and Gulati, Puranam and Tushman (2012) present a model which intends to describe these different variations of meta-organizations and how they are designed. This is done in a matrix where the first variable is low-stratification/heterarchical decision-making or high-stratification/hierarchical and the second variable of closed boundaries/membership or open boundaries/membership (Gulati, Puranam and Tushman, 2012). The membership can either be closed or open, and in a closed meta-organization a new member basically need an approval from the meta-organization to be let in (Gulati, Puranam and Tushman, 2012). In comparison, the open membership design is based on a self-selection to become a member (Gulati, Puranam and Tushman, 2012). However, what characterize a member and a membership is something we will describe further in the following section.

The other aspect of low- and high stratification intend to distinguish a high stratification which means to have an authority and role-based structure and a low stratification is associated with heterarchical and members have more overlapping rights and responsibilities (Gulati, Puranam and Tushman, 2012).

![Matrix showing variations in meta-organizations' designs](image-url)

**Figure 1.** This figure is a matrix which Gulati, Puranam and Tushman (2012) present when describing variations in meta-organizations’ designs.
Furthermore, the structure and functions of a meta-organizations have been discussed by several scholars such as Bor (2014), Rajwani, Lawton and Phillips (2015), Lawton, Rajwani and Minto (2017), Spillman (2017) and Ahrne and Brunsson (2005; 2008). Bor (2014) argue that the function of a meta-organization should be a collective playing ground for the members. Ahrne and Brunsson (2008) discuss three purposes which a meta-organization should be set up for, interaction among members, collective action among members, or create a collective identity. Furthermore, Rajwani, Lawton and Phillips (2015) and Tucker (2008) argue that a meta-organizations or trade associations may shape norms where the meta-organization may have a self-regulated role. Ahrne and Brunsson (2008) agree with this and do also discuss the aspect of how a meta-organization provides self-regulating rather than found laws, this since it might be hard for the meta-organization to establish laws.

2.1.1.2 Membership
As already mentioned, meta-organizations’ members don’t consist of individuals but of organizations (Ahrne and Brunsson, 2005; 2008) or according to others, individuals and/or organizations (Gulati, Puranam and Tushman, 2012). Depending on what kind of members the organizations consists of, the functions of an organizations ought to differ (Ahrne and Brunsson 2005). In general, one can say that organizations with individuals as members and meta-organizations have several features that are alike. However, individuals and organizations are quite different, and this will most likely affect meta-organizations in some ways, compared to other organizations. For example, Ahrne and Brunsson (2005), list some characteristics and differences between humans and organizations.

- “Organizations can be created and designed by individuals or by organizations, while human beings cannot.”
- “Organizations have life span that is hard to predict and that is often very short (Aldrich, 1999, Ch. 4), but that in some cases can be very long, whereas the mean human life expectancy us close to the median and all humans are mortal.”
- “Organizations have members, while human beings do not.”
- “We cannot meet an organization, whereas we can meet human beings.”
- “Organizations concentrate resources and have access to more resources than most individuals do.”
- “Organizations provide an organized form of collective action that, by definition, no single individual can do on their own.”
We argue that it is important when discussing member’s characteristics and especially meta-organizations to comment that the members of a meta-organization, that is organizations, consists of individuals. This would imply that those human beings active in the meta-organization have some sort of dual allegiance. According to Webb (2017), it is important that the individuals in the meta-organizations can identify themselves with both their *home-organization* and the meta-organization. Furthermore, Ahrne and Brunsson (2011) also discuss the fact that it can be differences in identities, especially between members and non-members of the organization.

As Gulati, Puranam and Tushman (2012) argue, when designing a meta-organization, the communication and decision-making processes are important to consider. Furthermore, they also argue that meta-organizations should consider its members own organizational strategies. Another aspect to consider in meta-organizations is that the members must make decisions jointly, however, they remain sovereign and autonomous as organizations (Ahrne, Brunsson and Seidl, 2016). We will discuss decision-making processes and members’ (often conflicting) interests further under next section.

### 2.2 Decision-making

Making a decision can be discussed from several perspectives, Kahneman and Tversky (1979) discuss how people make decisions under risk and how they assess the gains and losses of the outcome. Fox and Tversky (1988) study how decisions are made under uncertainty and present a two-staged model of judgement and risky decision weights. Janakiraman and Sarukesi (2006, pp. 15-17) discuss Simon and Newell’s decisions making model consisting of three steps: intelligence, design and choice. However, making a decision in a meta-organization compared to a non-meta-organization is described by several scholars to be different (Ahrne and Brunsson, 2005; Köning, Schulte and Enders, 2013; Berkowihtz and Bor, 2018), and that is discussed in the following section.

#### 2.2.1 Decision-making in meta-organizations

Making decisions in a meta-organization can sometimes be problematic, for example, because they usually don’t have a formal internal authority (Heine and Kerk, 2017), but also since organizations compared to individuals have more complex characteristics (Ahrne and Brunsson, 2005). Ahrne and Brunsson (2005) further explain that organizations differ from individuals because of the size and complexity of these organizations and bring up the example
of EU whose members are countries which all have different administrative and constitutional structures. To further elaborate on the EU case as a meta-organization, EU have their own leaders but also the member’s leaders to consider when making a decision (Ahrne and Brunsson, 2005). Furthermore, these members of the meta-organization have different status and power compared to each other and according to Berkowihtz and Bor (2018), decisions in meta-organizations can be problematic due to prioritization of the members. There might also be potential decision-making issues in the aspect of authority and identity, for example, who’s in charge in a certain situation and the distribution of tasks, meaning who should do what (Ahrne and Brunsson, 2005). Furthermore, accountability in meta-organizations can be associated with decision-making, meaning that who is accountable to who (Berkowihtz and Bor, 2018). Additionally, issues might occur because the members of the meta-organization are accountable to both their own organization but also the meta-organization, whereas the meta-organization is accountable to those who provides resources (Berkowihtz and Bor, 2018). This might be problematic since there will be multi demands from different directions and it might not be so clear of who has the priority (Bor, 2014; Berkowihtz and Bor, 2018). This is also discussed by Rajwani Lawton and Phillips (2015) who describe meta-organizations as a “voice for the industry”, which potentially leads to addressability and non-addressability within decisions-making (Berkowihtz and Bor, 2018). The example presented by Rajwani, Lawton and Phillips (2015) by having a meta-organization as “voice for the industry” and is hierarchically structured is considered addressable, in contrast, a meta-organization which doesn’t have a clear hierarchy and authority might be struggling with non-addressability (Berkowihtz and Bor, 2018). Berkowihtz and Bor (2018) explain this addressability and non-addressability to potentially be problematic when meta-organizations make decisions where members can hide from responsibility due to non-addressability. Heine and Kerk (2017) also study the decision-making process in meta-organizations but more emphasize the different internal conflicts which might occur in such a complex organization which a meta-organization is. They further discuss that the structure of a meta-organization can have flaws in making decisions, this is due to that these meta-organization might not have a formal authority (Heine and Kerk, 2017). This could lead to issues since the interest of each member might impair or block certain decisions in the meta-organization (Lumineau, Eckerd and Handley, 2015).

Furthermore, key decisions in a meta-organization are generally made in a parliamentary context where members vote and the meta-organization act as a moderator (Köning, Schulte and Enders, 2013). Köning, Schulte and Enders (2013) consider the decision-making process
to be rather slow in this context of voting, but they also argue it’s due to the more complex structure a meta-organization have. This is also discussed by Ahrne and Brunsson (2005) who argue that voting can as a resolution in a decision-making process could be problematic due to how a meta-organization is uphold compared to an individual-based organization. However, due to a complex structure, decisions are generally made through consensus which is a way of handling conflicting interests (König, Schulte and Enders, 2013; Ahrne and Brunsson, 2005; 2008; Berkowihtz and Bor, 2018), and the decision-making process of consensus is arguably resulting in a slow decision-making process (Berkowitz and Dumez, 2016). Moreover, Ahrne and Brunsson (2005) discuss the conflicting-resolution aspect of decision-making, and argue that to solve conflicting interests also depend on of what kind of decisions that are made i.e. laws, regulations, recommendations, policies etc. Meaning that decisions made and implemented by the meta-organization should arguably be regarding directives and recommendations to its members to follow, rather than laws and regulations (Ahrne and Brunsson, 2005). Nonetheless, König, Schulte and Enders (2013), Ahrne and Brunsson, (2005; 2008) and Berkowihtz and Bor (2018), all agree that decisions in a meta-organization are based on consensus-building.

In contrast to König, Schulte and Enders (2013), Ahrne and Brunsson, (2005; 2008) and Berkowihtz and Bor (2018), Karlberg and Jacobsson (2015) argue that decisions are not made by consensus. According to Karlberg and Jacobsson (2015), decisions made in the meta-organization are based on support by the majority of the members. The result in a faster decisions-making process relative making a decision on consensus. Additionally, Malcourant, Vas and Zintz (2015) partly agree with the consensus-building in decision-making. However, they argue that it does not occur under all circumstances and is nuanced depend on the circumstances.

Furthermore, an important aspect of which is brought up earlier is coordination and collaboration. This is also discussed to be a part of the decisions-making process in a meta-organization, where the meta-organization act as a coordinator for collective action (Ahrne and Brunsson, 2005). Moreover, collaboration is encouraged when creating clusters or networks between members in decisions and activities (Gulati, Puranam and Tushman, 2012).
2.3 Digitalization in healthcare markets

One could argue that digitalization is one of the most dominant global trends. Since it’s so extensive, the healthcare sector is not excluded of the power of digitalization. Hence, the term e-health has been developed and is shaping the healthcare infrastructure as we know today. This section intends to explain digitalization and the emergence of e-health in the healthcare sector.

Throughout the years major trends have shaped the society and organizations as we know today, one of those trends are the industrial revolution which could perhaps be acknowledged as one of the most significant in modern time (Jones, 2010). However, one of the most recent trends that is transforming the society is digitalization, which has become widespread in several organizations, and the core of this trend is the assumption that digitalization will improve the organization’s overall performance (Kotarba, 2017).

Due to digitalization, many so called e-services have emerged in different industries and when one explains or label e-services we usually call them; e-health, e-ticketing, e-banking, e-government, e-commerce etc. (Sheth and Sharma, 2007; Taherdoost, Shamsul, and Neda, 2013). One of those are e-health services which is closely correlated to digitalization in terms of automating and improving cost-effectiveness in the healthcare sector (Langabeer, James and Champagne, 2016; Della Mea, 2001; Eysenbach, 2001). Moreover, the term e-health is described as a broad concept of the integrated parts of telecommunication and information technology, thus the usage of digitalized data in healthcare (Della Mea, 2001). For example, in healthcare there are several areas e-health have been implemented, one of those are information technology (Langabeer, James and Champagne, 2016). Electronic health records (EHR) is such a case, which basically means that actors in healthcare digitalize analog materials (Vadillo et al., 2016; Harrington, 2014). Vadillo et al. (2016) argue that implementing and digitalizing healthcare have it challenges, however, improving quality, reduce administrative costs and prevent medical errors are opportunities which exceed the challenges. Although there are opportunities with EHR and other e-services, some argue that the e-services e-health provide it’s still far from user friendly for clinicians (Ratwani, Hettinger and Fairbanks, 2017, Harrington, 2014).
2.4 Summary

Digitalization is undoubtedly a trend that has impact in several industries. Healthcare is one of them, where Vadillo et al. (2016) and Harrington (2014) for example, discuss electronic health records (EHR) and Langabeer, James and Champagne (2016), Della Mea (2001) and Eysenbach (2001) discuss e-health and what it can contribute with in healthcare. However, as Kotarba (2017) explains more broadly, digitalization is implemented in the sense of improving firms’ overall performance.

There has been conducted a lot of research studying meta-organizations and its characteristics. Ahrne and Brunsson (2005) are one of the first who attempts to define what a meta-organization is, which is an organization-of-organizations. They emphasize two fundamental factors which characterize a meta-organization, the environment and its members (Ahrne and Brunsson, 2005). The environments can be viewed as an uncertainty for individual organizations and by joining a meta-organization which gather many organizations below its umbrella. By doing so, the uncertainty for member-organizations decreases where the meta-organizations work as a tool to transform the environment to the meta-organization. This will provide the member-organizations with collaboration and coordination between the members. The second factor which meta-organizations relies on is its members. Where Ahrne and Brunsson (2005; 2008) define the members as organizations, thus organization-of-organizations, but in comparison Gulati, Puranam and Tushman (2012) have a partly similar view but also include individuals when considering whom can be a member of a meta-organization.

Moreover, (Bor, 2014), Rajwani, Lawton and Phillips, (2015), and Ahrne and Brunsson (2005; 2008) discuss how a meta-organization is structured and what functions it could have, for example in terms of self-regulating and shaping norms in the industry. Additionally, even if a meta-organization can gather several members of an industry and may reduce uncertainty of the environment, the decision-making process can sometimes be complicated. This aspect has, for example, been discussed by Berkowihtz and Bor (2018), Heine and Kerk (2017), Lumineau, Eckerd and Handley (2015) and Ahrne and Brunsson (2005; 2008). Where Berkowihtz and Bor, (2018), for example, explain that the priority of whom of the members that should be prioritized can be complicating when making a decision. Heine and Kerk (2017) show in their study that the lack of authority could be a factor of possible internal conflict. Lastly, Karlberg and Jacobsson (2015) discuss the decision-making process in a meta-organization and argue that decisions are not made by consensus but rather of the opinion of
the majority of the meta-organizations members. This contradicts with what Köning, Schulte and Enders (2013), Ahrne and Brunsson, (2005; 2008) and Berkowithz and Bor, (2018) discuss in meta-organizational decision-making, where they argue that decisions are based on consensus amongst its members.

2.4.1 Conceptual model

To conceptualize, we have made a model that will show how decision-making research, meta-organizational research and how demographics, healthcare and digitalization all relate to each other. The first element in our conceptual model is the decision-making process, that we have described in our theory section is defined as consisting of collaboration (coordination is considering to be so closely related that we choose to include it in collaboration) and interest conflicts. Meanwhile, the second element in our conceptual model is how meta-organizations in the theory section can be defined by members and non-members. These two elements together form the core of our study, we want to explore and further explain decision-making processes and in a meta-organizational context. The third element in our conceptual model are about the concepts of environments, surroundings and context of the study, which is demographics, healthcare and digitalization. These concepts are about how the meta-organization and its decision-making processes relate to outside phenomenon of our study. These last concepts are also necessary to at least briefly explain and include in our study because meta-organizations are defined partly by concepts of environments and non-members (which is part of the environment).

This model is also designed from an empirical perspective in such a way that these theoretical concepts relate to our empirical findings. This is also an argument for why we have included the concepts of demographics, healthcare and digitalization.

Figure 2. Conceptual model.
3 Methodology

Under this section we will present our thought on research and theory, our study’s methodology for literature review, data collection, data analysis and finally how this study stands in terms of trustworthiness and ethical considerations. Some parts of this sections are more theoretical founded, some parts are more integrated and consist of both theory about research and methods, and practical description of how we went about our research. Some section is more of practical descriptions.

3.1 Research strategy and study design

A common categorization of research in business studies is quantitative and qualitative approaches (Bryman and Bell, 2015, p. 37). In business studies both quantitative and qualitative research approaches are commonly used, some researchers use either one of the approaches, others may use both. The choice between using the either, the other or both approaches have to do with how the researcher look on theory building and which ontological and epistemological considerations that one must make (Bryman and Bell, 2015, p. 37). We have chosen a qualitative approach, or strategy, to best pursue our explanatory and exploratory research question of answering questions such as how and what and why (Bryman and Bell, 2015, pp. 406-407).

Since we chose a qualitative research approach and want to understand a specific behavior in its specific social context. Therefore, as overall research design, we chose to perform a case study within the context of the Swedish public healthcare market. Moreover, in this study our case consists of a group of key organizations that together hold a significant share of the market in terms of influence, knowledge about the market and recent trends, challenges and opportunities within the area of digitalization in healthcare. Case study design approaches is common in business studies (Eisenhardt and Graebner, 2007) and often focuses on precise settings, often specified in geographical terms (Saunders, Lewis and Thornhill 2012, p. 179; Bryman and Bell, 2015, p. 68). Another reason for us we are believing that a case study design was appropriate, were because we were interested in explaining and explore a phenomenon that could be empirically be described by a group of specifically chosen key organizations. In our case study we have localized SALAR and its subsidiary in E-health, Inera AB as the meta-organization. We have also included informants and documents from some of the members and non-members of the meta-organization. Furthermore, case study designs often favor qualitative methods (Bryman and Bell, 2015, p. 68), which also argue for this
approach because of the qualitative nature of our research question. In accordance with Saunders, Lewis and Thornhill (2012, p. 179) we believe that a case study design is appropriate because we have explanatory and exploratory research question. Moreover, a case study allows for an intensive study of a phenomenon (Bryman and Bell, 2015, p. 67), which is exactly what we set out to do with our study. Moreover, case studies are often used to highlight the uniqueness of a situation (Bryman and Bell, 2015, p. 68), which also suits our study well since we want to do understand a specific a situation that have not been observed in the Swedish healthcare market before. One can say that the whole phenomena is quite unique, that is digitalization of public healthcare.

3.1.1 Inductive and deductive theory building

There are mainly two ways for the researcher to look upon theory and research, namely deductive and inductive approach, however, we will also discuss the abductive approach, that is, the approach we have chosen for our study.

Deductive view on theory and research is the most common one and means that the researchers starts with theory and deduces a hypothesis. From that hypothesis the researcher collects data and summarizes the empirical findings. Roughly, the hypothesis it either confirmed or rejected, which leads to revision of theory (Saunders, Lewis and Thornhill 2012, pp. 144-145; Bryman and Bell, 2015, p. 23).

Inductive view on theory and research is almost the other way around compared to deductive theory. If the researcher has an inductive view on theory and research the theory is an outcome of research. The research starts with observations, or data, and then induces it to build theory (Saunders, Lewis and Thornhill, 2012, pp. 144-145; Bryman and Bell, 2015, p. 25).

Qualitative research often uses inductive theory building and world-views that is based in interpretivism and constructionism (Bryman and Bell, 2015, p. 38). Furthermore, deductive views are commonly associated to quantitative approaches (Bryman and Bell, 2015, p. 25) and to natural sciences (Saunders, Lewis and Thornhill, 2012, p. 145), while inductive views is commonly associated with qualitative approaches (Bryman and Bell, 2015, p. 25) and with social sciences (Saunders, Lewis and Thornhill, 2012, p. 146).

However, after thorough discussions between the authors, arguing which approach we believe the strongest in we reached the conclusions that these views were to take too extreme positions on either way. Thus, we believed both not sufficient enough for our study.
design. Therefore, the third view presented itself to us, that is, the abductive theory view, which we will further discuss in next section.

### 3.1.2.1 Abductive theory building

This view on theory and research is a view that draws elements from both the deductive and inductive views. We believe that this is a more pragmatic view on how to treat theory and research. Because of this, abductive reasoning is growing in business studies research (Saunders, Lewis and Thornhill, 2012, p. 147; Bryman and Bell, 2015, p. 27). One way of describing abductive reasoning is that the phenomenon that the researcher wants to study is a puzzle. This puzzle, the researcher wants to explain and understand better. In short, the abductive view allows the researcher to move back and forth between theoretical constructs (and the literature) and the empirical findings, that is, the collected data (Bryman and Bell, 2015, p. 27). We believe that this abductive reasoning is more suitable for our explanatory and exploratory research question. Moreover, since we did not know before we started our study which theory that were best choice, neither did we know how much data beforehand that would be needed to explain the phenomena. Therefore, we constructed our theoretical framework alongside with our data collection, and analysis of our empirical findings. An example our abductive approach it that after each transcribed and summarized interview, we had discussions about the findings between ourselves, and we consulted the literature one again and sometimes led us to revise our theoretical framework.

Regarding our previous discussions about qualitative approach an, case studies that have a qualitative nature often tend to be inductive (Bryman and Bell, 2015, p. 69), however, we believe that our abductive way to theory and research was aligned with our strategy and case study design choice. Though, as briefly mentioned before, we believe that inductive and deductive approaches as they are described in methodology literature, often take extreme positions on research and theory. Thus, making abductive reasoning more relatable to our position on how to conduct research and contribute to theory.

### 3.1.2 Epistemological considerations

We have already stated that we used an abductive reasoning throughout our study, which ultimately means that we use both inductive and deductive views on theory and research. How to treat theory and research have a lot to do with how to treat knowledge and what can be considered knowledge. Positivism is one deeply rooted doctrine in business studies
and builds on both inductive and deductive views (Bryman and Bell, 2015, p. 27). Formulated like that, one could think that we have a positivist’s way of approaching science in general and our study in specific, however, we have not completely adhered to this doctrine. Since positivism sees theory as means to formulate testable hypothesis’ (Saunders, Lewis and Thornhill, 2012, p. 134; Bryman and Bell, 2015, p. 28) we believe that positivism is too strict for us.

Interpretivism, however, is more about finding the ‘subjective meaning of social action’ (Saunders, Lewis and Thornhill, 2012, p. 163; Bryman and Bell, 2015, p. 29) and in line with our fluent way of treating theory and research. What this means for us in our study is that we can use our informants spoken works and thoughts, all the written words in our collected documents also. We can subscribe meaning to these written and spoken words (Saunders, Lewis and Thornhill, 2012, p. 137; Bryman and Bell, 2015, p. 30) and after analysis we can treat this as new knowledge.

3.1.3 Ontological considerations

Ontology is about how to understand social entities and reality, whether these social entities should be viewed on objectively or in relation to social actors (Saunders, Lewis and Thornhill, 2012, p. 130; Bryman and Bell, 2015, p. 32). That is, the social behavior that we study and want to understand, is either independent from us as social actors or it is not. These different views on reality is commonly named objectivism and constructionism (Saunders, Lewis and Thornhill, 2012, p. 131; Bryman and Bell, 2015, p. 32).

Objectivism sees the phenomenon as independent from the social actors (Saunders, Lewis and Thornhill, 2012, p. 131; Bryman and Bell, 2015, p. 32) which for our study means that the case organizations in our study are as they are regardless of social actors in their surroundings. Furthermore, these organizations’ members are subject to the characteristics of their organizations.

Meanwhile, constructivism, or more commonly named subjectivism (Saunders, Lewis and Thornhill, 2012, p. 132), sees things differently. The phenomena are not independent from social actors and its surroundings, including the researcher’s ‘version of social reality’ (Saunders, Lewis and Thornhill, 2012, pp. 131-132; Bryman and Bell, 2015, p. 33). This ontological way of looking upon reality and the phenomena that we studied suits our previous discussion about abductive reasoning and how we want to ‘interpret’ the findings from our case in the Swedish public healthcare market.
3.2 Triangulation

Our case study design and abductive reasoning also aligns nicely with the concept of triangulation. This concept means that we use different sources of data (Saunders, Lewis and Thornhill, 2012, p. 179; Bryman and Bell, 2015, p. 402). One of the main reasons to triangulate in one’s data collection is to increase the research quality and validity (Bryman and Bell, 2015, p. 242; 402; Saunders, Lewis and Thornhill, 2016, pp. 206-207). Here we employ the understanding that validity can, after some modification, be of importance as a quality criterion to qualitative research (Bryman and Bell, 2015, p. 400). Ultimately, the idea of triangulations means that the conclusions that we have drawn about our data ought to align with the reality of what we have studied, since multiple sources provide a nuanced picture, in contrast to a more simplistic single-source interpretation. Specific to our study, triangulation in our data collection will show itself in such a way that we use interviews conducted by ourselves, interviews conducted by third-parties (e.g. in podcasts and news reporters in media), and we also use archival data such key documents (such as agreements and reports), and media (investigative) articles presented in Swedish major newspapers and websites belonging to our case organizations. For example, in our triangulation process, after an interview we cross-checked the findings with other data sources such as an economic report or news article. This left us with a more nuanced picture of situation, which ultimately deepened our understanding of the empirical situation within the digitalized public healthcare market.

3.3 Literature collection

The objective in our theoretical section is to achieve a better knowledge of what research that has been done within our research topic. From much of the practical and empirical trends, and from the initial overlook of the Swedish healthcare, we started looking into the field of risk and risk management. The notion of meta-organization where present here also, however, as the process of this thesis prolonged our focus changed towards the fields of stakeholder theory, networks and organizational structure. When we got access to our case organization with interviews with informants and got into the documents, we saw that our interest was more of how decisions are made and how the meta-organization organize itself in relation to these decisions-making processes. Therefore, our final theoretical and analytical framework is about meta-organizations and decision-making. Since we have chosen an organization and a sector that currently experience demographic changes and the contemporary phenomena of digitalization, we believed that we need context-based research
to better understand the environment of the case organization. Also, theories and research about meta-organizations involves elements such as environment, thus, making context-based research needed for that reason.

Concretely, when gathering academic articles, we used Uppsala University (UU) library’s and Google Scholar’s (GS) search engine. When we used UUs searches we had the following filters; full-text, articles, peer-reviewed, English and scientific journals. When we used GS’s engine we simple searched without any filters because the search engine was not sophisticated enough for this. In our searches, we used key words in different constellations and combinations, for instance, “digitalization”, “digitalisation”, “healthcare”, “decision-making” and “meta-organization”. The well-known names of researchers in respective field were also included in our key-words to track their work. We also used books in our literature review and these were selected by the names of well-known researchers in respective field. When deciding which researcher that is well-known we simply looked for those that reoccur often in articles in our field of research.

### 3.4 Data collection

Our data set can be categorized in primary data and secondary data, which we will present in next section. We would like to emphasize that we have not conducted an interview study, that is, our data set is not focused around the interviews. However, the interviews have had a central significance because they have provided us with information about key documents and other key informants. As already mentioned, our study uses both interviews and other sources of data. Primary data can be defined as data collected by the researchers themselves with their own specific purpose, in contrast to secondary data which is collected by someone else with a different purpose (Bryman and Bell, 2015, p. 13; Saunders, Lewis and Thornhill, 2016, p. 316). For us, this means that our primary data consists of interviews conducted by ourselves in purpose to answer our research question. While secondary data in our study have been interviews conducted by third parties, key documents, websites, and media articles (both investigative presentations and interviews).

A brief comment about the quantity of data collected can be said. The six interviews conducted by ourselves generated approximately 52 pages and 24 000 words in transcripts and the four podcasted interviews generated about 27 pages and 11 500 words. Meanwhile, total amount of documents in form of budgets, annual reports, agreements and policy documents amounted to approximately 550 pages. The governments investigations (SOU:s)
have not been included in the page count, though we use them to better understand the case context. Media articles and websites that we considered to be empirical data have not been meaningfully quantified in this manner.

3.4.1 Sampling process
Since both authors initially had limited knowledge of how digitalization in healthcare look like and which challenges and opportunities it poses for the different actors within healthcare market, a natural starting point of this study was to browse for information on organizations websites and read media articles regarding the subject. From this preliminary and unstructured data collection we found names on key persons at key organizations that could be contacted as informants. Furthermore, we also found key documents that we could use. This sampling process lead to an initial understanding of the situation. We then contacted these key persons for interviews. Besides the data collected in the interviews relevant to our research question, we got additional names for key persons with specific positions, knowledge or understanding of the topic. Furthermore, in these interview additional key documents were brought up. Our sampling process could therefore be described as continuous and like a snowball selection. We believed this were best suited for our study because the digitalization of the Swedish public healthcare sector is a currently ongoing phenomenon and our research question is of explanatory and exploratory nature. This sampling method is, as already mentioned, and called snowball sampling (Bryman and Bell, 2015, pp. 434-435).

3.4.1.1 Primary data
In this study, data has been gathered through interviews and discussions with key actors from our chosen organizations. The purpose of the interviews and discussions has been to gain insights of our research area in general, but also to get knowledge of additional key actors and key documents that concern our research question. The interviews were so-called unstructured with an interview guide with topics and broad questions, which, in concordance with what Bryman and Bell (2015, pp. 213-214) suggests, enabled us to ask follow-up questions. This option, we believed, ultimately benefited and expanded our knowledge of the topic. Before the interviews, all the informants received the interview guide via e-mail and were also able to clarify or ask us about the topics. The interviews were held via telephone or in-person and ranged between 25 minutes to 60 minutes. Moreover, from an ethical
perspective, all interviews were carried out in a professional manner and before participating, the informants were informed of who we are, the purpose of the interviews, as well as the research itself and how we would treat recordings, transcripts and finally the presentation of the data. Additionally, informants and their organizations and opportunity to be anonymous, however, they chose not to be that. A list of self-conducted interviews is presented in Table 1 below.

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Function / Role</th>
<th>Date</th>
<th>Time frame</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashgar Farahani (A.F.)</td>
<td>Member-organization</td>
<td>County manager</td>
<td>2018-04-04</td>
<td>25 minutes</td>
<td>Telephone</td>
</tr>
<tr>
<td>Agneta Rönn (A.R.)</td>
<td>Meta-organization</td>
<td>Senior expert</td>
<td>2018-04-06</td>
<td>40 minutes</td>
<td>Telephone</td>
</tr>
<tr>
<td>Lars Kolmodin (L.K.)</td>
<td>Meta-organization</td>
<td>Senior official</td>
<td>2018-04-11</td>
<td>60 minutes</td>
<td>In-person</td>
</tr>
<tr>
<td>Patrik Sundström (P.S.)</td>
<td>Meta-organization</td>
<td>Program supervisor</td>
<td>2018-04-17</td>
<td>40 minutes</td>
<td>In-person</td>
</tr>
<tr>
<td>Monica Johansson (M.J.)</td>
<td>Member-organization</td>
<td>Politician</td>
<td>2018-04-26</td>
<td>35 minutes</td>
<td>Telephone</td>
</tr>
<tr>
<td>Louise Gottlind (L.G.)</td>
<td>Non-member organization</td>
<td>Project manager</td>
<td>2018-05-03</td>
<td>35 minutes</td>
<td>Telephone</td>
</tr>
<tr>
<td>Sofie Zetterström (S.Z)</td>
<td>Meta-organization's subsidiary</td>
<td>Vice President</td>
<td>2018-05-07</td>
<td>35 minutes</td>
<td>In-person</td>
</tr>
</tbody>
</table>

Table 1. Primary data; Interviews.

### 3.4.1.2 Secondary data

In parallel to our interviews, we also collected data consisted of interviews carried out by others than us selves. These interviews were performed by somebody else than ourselves and with different objective or purpose compared to our research. This is what is typically defined as secondary data. A brief comment about some of the interviews we used in our data set is that they are, as already mentioned, carried out by third party interviewers (in this case it was representatives from the meta-organization) and aired in a video-podcast through YouTube. The podcasted interviews we used in our study ranged from 20 to 25 minutes. The participants in these interviews were localized as key information’s in the same way that we found informants for our self-performed interviews, that is, by a snowball sampling process. How we analyzed these interviews are further described under section 3.5 Method for data analysis. The third-party interviews used in our study are presented in Table 2 next page.
Furthermore, as additional secondary data, we used various documents that was at our disposal. These key documents were also found by using a snowball-sampling process where we looked for their presence in media, on our case organizations’ websites and when brought up in interviews (both our own and third-party). Documents are presented in Table 3 below.

Table 3. Secondary data; documents.
* Number of pages in total, however, not all used as empirical data for our study.
3.5 Method of data analysis

The thematic analysis of all our data was a continuous process where we frequently revisited and revised our research question and literature. For us, this proved to be a challenge, however, we believe that has been beneficial since our case study were exploratory and new findings and angles presented itself along the way. This means that the analysis of primary data (interviews) and secondary data (interviews and documents) were conducted in parallel with each other and searching for literature. However, for the cause of presentation in this paper and dissimilarities between sources of data in how analysis was made, the process is divided in separate sections. Our codes, or themes, that we used in our analysis was coordination, collaboration, interest-conflicts, members and non-members.

3.5.1 Thematic analysis of primary data

The objective of our data analysis is to gain an understanding and interpret the situation. This kind of analysis is an ongoing process (Kaplan and Maxwell, 2005). Both authors were present and performed the interviews (those conducted by ourselves), both authors took notes and both asked follow-up questions. In a matter of speech, the data analysis started during the interviews. All interviews were recorded because we wanted to be able to listen the interviews again later in our study, and because we wanted to transcribe the interviews. Directly after each and one of the self-performed interviews, we transcribed them. Each interview was transcribed by one author, not by both, simply because we wanted to save time. Next step was that both authors individually summarized the transcripts and made comments. The summaries were used as an easier way to overlook the data and get a preview of our results. Transcripts were then thematically coded using our theoretical framework and especially interesting citations were noted.

3.5.2 Thematic analysis of secondary data

Continuously, we then made a thematic coding of the transcripts and discussed the summaries between the authors and sent the transcripts to respective informant for approval, feedback and follow-up comments. Involving the informants in this phase of data collection and analysis we believed increased the level of quality in the data since we got more data and the informants got the opportunity to clarify and develop their answers, each interview was summarized and analysis individually by the authors and then discussed together. We believed that this process enhances the depth and quality of the data analysis since each researcher
then had the opportunity to form one's own opinion and then in the discussions we could compare our understandings of the data. According to us, this is both a thorough way of analyzing the data and a way of assuring that the findings do not get affected by bias.

In the case of our documents (and here we are including media articles), the process was similar since both authors read them, summarized them and translated them. After individually analyzing the documents we discussed and compared our understanding of the data. Both documents and third-party interviews were thematically analyzed with the same research question and theoretical framework in mind as the primary data.

### 3.6 Research ethics and Source critical consideration

Gathering data in a qualitative research, it’s important to consider and address the ethical aspects that could arise (Brinkmann and Kvale, 2015). The method and usage of the collected data have been in accordance to *Good Research Practice* (2011). Before interviews, informants were given the opportunity to be anonymized both personally but also what organization they represent, interviewees were also informed of the study’s purpose before conducting the interview. Furthermore, interviews were recorded in agreement with informants to be used only in the purpose of transcribing and not be distributed to a third party. After transcription interviewees had the opportunity to read the transcription of the interview and give additional comments if wanted to.

To achieve a trustworthiness in a qualitative study such as this, one shouldn’t strive to review criteria of reliability and validity which is more commonly used in quantitative research. One should rather measure the quality of the research by using *credibility, transferability, dependability* and *conformability* (Bryman and Bell, 2015, pp. 50-52).

The first criteria *credibility* is referring to what extent this study is reflecting the social reality (Bryman and Bell, 2015, p. 401). Bryman and Bell (2015, p. 401) discuss the concept of informant validation which aims that the researcher has perceived and understood the interview correctly. In this study, credibility has been conducted by first sharing the transcription with the participant and then ask informants for approval and opportunity to give additional comments on the interview. Additionally, to informants’ validation, this study conducts a triangulation which objective is to assess both documents and interviews.

*Transferability*, since qualitative research generally consists of a smaller data set compared to quantitative research, therefore, this study intends to have a depth rather than
a width (Bryman and Bell, 2015, p. 402). Therefore, this study’s intention is to create a thick
description of a phenomenon.

According to Bryman and Bell (2015, p. 403), *dependability* refers to that the findings
and thesis process is stable over time. The authors intend to follow the criteria of
*dependability* by clearly present a detailed process-overview of how this study was conducted.
In this study, we have had a continuous peer review process in the sense of having seminars
where our research process was presented and discussed.

To achieve *confirmability* authors must act in good faith and stay objective in the sense
of not allow research biases of personal values or judgements (Bryman and Bell, 2015, p. 403).
While it’s hard to be completely objective, the author’s intention is biased personal values will
not affect this study.

### 3.7 Limitations

Some limitations of this study are rather obvious, and it’s related to the time horizon of it,
the resources at our disposal and of course our own experience. The time horizon of this
study make access to interviews critical and the importance of structure and planning of the
research process is high. Our limited resources affect us in such a way that we cannot provide
any rewards or compensation for participation of our informants, neither can we outsource
the time-consuming task of transcribing.

Related to our study design, since we have chosen a qualitative research an approach
we cannot generalize our empirical findings in such way that we can say that our case is
representative for all cases (Bryman and Bell, 2015, pp. 56; 414). However, qualitative research
can achieve theoretical generalization in such way that our empirical findings can relate to
previous theory and therefore included in a broader theoretical significance (Marshall and
4 Empirical findings

In this section we present our empirical findings. Since our study is within the Swedish healthcare sector, we believe it’s important to first present a thick description of the empirical context thus providing a richer understanding of our case. Therefore, we will describe our case context, that is, the Swedish digitalized public healthcare, our case organization which is the meta-organization and the demographical environment. The following part of this section we will be structured in theoretical themes which we derived from the conceptual framework.

4.1 Case context

4.1.1 Swedish healthcare and digitalization

Since this study is within the Swedish healthcare, we believe it’s important to first give a brief introduction how the Swedish healthcare looks like. In comparison to other countries, the Swedish healthcare can be considered as in the forefront in medicine, care and medical technology (P.S. and H.S.), however, in development and implementation of digital technology in healthcare, Sweden can be considering to be behind (P.S.). For example, there’s technology today which can solve problems such as integration of journals between counties, however to implement digital solution in the healthcare there’s a need of investment in the infrastructure in the Swedish healthcare (H.S. and M.J.). Furthermore, the Swedish healthcare sector is characterized as publicly funded (Anell, Glenngard and Merkur, 2012), and is characterized by its decentralized structure where the 21 county councils (and regions) have responsibility for the health care system. (SALAR 2018; Doc L).

Furthermore, there are an increasing number of private actors in the Swedish healthcare (A.R.; M.J.; P.S.; L.K. and Doc B). There are national laws and regulations that stipulate what and how healthcare should be provided and carried out:

“Healthcare is about the efforts that are being made to nurture those who are sick and the development of healthcare. Care should be equitable, equal and accessible and be offered based on needs on equal terms. An adapted healthcare system means that care should be given to the individual patient’s needs.”

- Government offices of Sweden, 2018. (Authors translation)

However, much of the regulations is locally mandated to the municipalities and counties. For example, reimbursement models in primary care and guidelines are locally decided. Therefore, there is variation in how care is carried out and how caregivers operate across Sweden (A.R.;
P.S.; L.G. and S.Z.). One actor that has a central position in Swedish healthcare is the interest and employers’ organization SALAR which will be further described under next section. Furthermore, the vision for year 2025 in Sweden is to be the best country in the world to utilize digitalization’s and e-heath’s possibilities, with purpose to achieve a fair and equal health for it’s people (Doc A; Doc D; Doc E; Doc F and Doc M). To reach this objective, there’s an initiated collaboration between SALAR and its members (Doc D).

4.1.2 Demographic development

As mentioned earlier in the problem background, one of Sweden’s demographical challenges is an increasing population (SCB, 2018), increasing elderly population (Ippolito et al., 2016) and increasing multi-illness (Läkartidningen, 2010). This is further confirmed by our informants and documents which present the challenges that the Swedish healthcare sector is facing and the need of efficiency in the health care sector (A.R.; R.M.; B.W.; Doc B; Doc C; Doc G and Doc M). For example, Document G describe that Sweden’s population is growing, however, the challenge is how it’s growing. Meaning that the two groups of young and elders are the two groups which are both in most need of care and growing fastest (Doc G). The two following quotes are examples of demographical challenges from one of our interviews and documents.

“It is important to say, and it applies to the whole healthcare, that we are facing very large challenges in healthcare in the future because we have this population development. We have fewer in working age, and more who need medical care. Therefore, we will need to make the healthcare more efficient, to cope with this.”

- Senior expert A.R., 2018. (Authors translation)

“Patients with complex needs, including chronic and multi-ill, are patient groups that require extensive care, which are logistically complex and with many care contacts. It is patient groups that are relatively few of individuals, it is about a few thousand patients in our county, but who account for a very large proportion of the healthcare resources.”

- Document C, p. 3. (Authors translation)

This demographic development is further discussed by our informants which also highlight the economic and tax perspective of having an increasing elderly population. According to one of our informants, a challenge for the Swedish healthcare is the increasing costs in the Swedish
healthcare (B.W.). Furthermore, other informants discussed the increased tax burden that we are facing, which is a result of the labour force of the population isn’t growing as fast as needed (R.M.). Moreover, one of the documents present different procurement which SALAR have made and emphasise the purpose of these procurements which is to increase efficiency (Doc J). When describing efficiency, they refer to the value which is produced in relation to how much resources that have been used (Doc J).

### 4.2 Case organization

The Swedish association of local authorities and Regions (SALAR), in Swedish *Sveriges kommuner och landsting* (SKL), is an employers’ organization and a local government representative in Sweden which is politically directed (SALAR, 2018). The members of SALAR consist of 290 municipalities and 21 counties/regions in Sweden (SALAR, 2018), whereas the municipalities are more local relative counties and regions which cover a larger geographical area. The counties and regions responsibilities are divided into geographical areas in Sweden where the main tasks consist of healthcare, dentist care and development of healthcare in respective region (SALAR, 2018). Within healthcare, SALAR’s (2018) focus is to continue to develop the healthcare in Sweden with the patient in centre. Moreover, SALAR (2018) has a broad range of tasks such as arranging network meetings among the counties and regions to discuss strategy and cooperation but also to work with inquires requested from its members. A part of the meta-organization SALAR is one of its subsidiaries, Inera AB that currently develop and provide E-health solutions and services to the meta-organization’s members, non-members, citizens and decision-makers (Inera, 2018; SALAR 2018).

### 4.3 Decision-making in meta-organizations

Since we are studying the decision-making process of a meta-organization, we’re emphasising two themes of *collaboration* and *interest-conflict*. However, we could derive different aspects of these themes from our theory and data which is presented in our following section.

#### 4.3.1 Collaboration

To work collectively and cooperate between the members of SALAR, different networks consisting of representatives from the members and SALAR have been establish (A.R.; A.F.; S.Z.; M.J.; P.S.; L.K.; Doc F; Doc K and Doc M). In these networks, there are regular meetings where members can discus decisions, recommendations and broad questions regarding
healthcare (A.R.; A.F.; S.Z.; M.J.; P.S.; L.K.; Doc F; Doc K and Doc M). Document M gives examples of these groups and networks and what they should consist of in SALAR.

“The cooperation groups shall be staffed with experts and representatives from the respective healthcare regions and from SALAR. The cooperation groups, if deemed relevant, may also consist of representatives from authorities and other stakeholders.”

-Document M, p. 151. (Authors translation)

One of our informants (A.F.) further explains how, in practice, these network meeting works and what sort of subjects they may discuss. That quote is followed by information from the SALAR’s website where the purpose and aim of these healthcare networks are described, which for instance is questions of management and control of healthcare issues, but also to share knowledge and skills between the members of SALAR.

“Then sometimes they usually call in some groups that are not in a service position but from expert network, where they can discuss e.g. mental ill-health. […] Almost all the areas are senior officials which meet very regularly, and there you raise all major issues with others from the country.”

-County manager A.F., 2018. (Authors translation)

“All Sweden’s county councils and regions are members of this network whose responsibility is public health issues. It started in its current constellation in 2000 and became in 2010 one official network in SALAR. The overall aim is to work together to strengthen public health and to reduce health differences between and within different groups of the population. Then it is essential to bring in public health issues in management and control. The network is also aimed at exchanging skills and pursuing proactive work for social sustainability.”

-SALAR Website, 2018. (Authors translation)

Furthermore, according to our informants and documents, the cooperation and collaboration with non-members of SALAR, i.e. private actors, are important but sometimes difficult (L.K.; S.Z.; L.G.; M.J.; A.F. and P.S.). These private actors are also sometimes involved in networks where SALAR either invite them or meet with them separately. This is for them to share who they are and what purpose and role they play in the Swedish healthcare (P.S. and L.G.).
further explains the sometimes long and rough path a private actor must go until its product or service is fully integrated in the public healthcare.

“By 2017, 134 innovation projects had received EU funding, but only one of them was eventually implemented in health care. I think it is a rather interesting challenge to think that there are very many private actors and innovators, but it is a thorough way to get into the care and to implement that product or service”

-Project Manager, L.G., 2018. (Authors translation)

M.J. further describes the role of private actors and how they affect the public healthcare in a sense. M.J. also discuss how to collaborate between private actors and SALAR, that sometimes can be problematic. However, this collaboration is more important today aspect today since there are many more private actors in the Swedish healthcare sector.

” The interaction and cooperation with municipalities and other healthcare centers now plays an increasingly important role, for example, around elderly, multicultural people who have a lot of support and help with home care. [...] Since there are so many actors today, municipalities, private actors, county councils and regions, we need to ensure that how we secure and get faster with transfers from the information between us, SALAR must gather the result and be the party discussing with the state, parliament and government.”

-Citizen-elected county official M.J., 2018. (Authors translation)

P.S. also describes the cooperation and collaboration between members of SALAR and private actors and explains that there are barriers for the private sector to initiate partnerships with the public healthcare sector. However, although there are barriers for private actors there are both networks and crowdsourcing/crowdfunding initiated to increase the collaboration and coordination between non-members and members (P.S.; Doc H and Doc I).

"In the coming years we will see very good solutions coming from the industry and new partnerships with the public sector will be initiated when the public sector opens up for help to find solutions. But today it’s still very difficult for an entrepreneur how to get in contact with the county or regions.”

-Program supervisor E-Health P.S., 2018. (Authors translation)
Documents and informants also describe the collaboration in terms of how members and the meta-organization work with objectives (E.S.; R.M.; M.J.; A.F.; Doc M and Doc O). Document M describes the cooperation, that members work toward a common goal and how knowledge is transferred between the members.

“That county councils and regions in collaboration work on the common vision: Our success is counted in life and equal health. Together, we make each other successful. That county councils and regions cooperate within the common structure of knowledge management.”
-Document M, p. 148. (Authors translation)

Document F further describe possibilities of cooperation between counties and that an ecosystem is seen as an important factor of success. Also, the Document F mention the collaboration between Inera, Kommentus and SALAR, this is also presented and confirmed in Document K.

“With good digital services and increased openness, residents and companies can take responsibility and control over their daily lives in a new way and contribute themselves to the development of society. To achieve this, there is a need for increased digital cooperation between municipalities, county councils, regions, state authorities and industry. [...] The need is endless, everything can’t be done, a planning and prioritization is needed. But Inera is not alone, collaboration takes place with Kommentus and SALAR. An ecosystem with SALAR and industry is seen as a success factor. Extensive work has been carried out”
-Document F, pp. 10-11. (Authors translation)

Furthermore, our informants and document describe the cooperation between members in the context of digitalization (A.R.; M.J.; P.S.; S.Z.; Doc K; Doc F and Doc H). Examples of collaboration and coordinated actions founded in our empirics are: integrated electronic journal system, recommendations on reimbursement models and utilizing digital innovations between counties. For example, one of our informants M.J. express the need of working together between counties and gives the example of the electronic journal systems and how SALAR should move forward with this matter.
“I think SALAR should work on even harder to, for example, that we should have a common journal system throughout the country. Today we have many actors, 21 counties, 21 different actors on the field and everyone thinks are so terribly unique. […] And here I think SALAR would have a far more prominent role and they work a lot with companies. […] I think that SALAR decides to go forward a bit tougher and a little faster now. I think SALAR needs to drive even harder against the state to get to this done.”

-Citizen-elected county official M.J., 2018. (Authors translation)

Informant S.Z. express that the cooperation between counties, regions and municipalities have come a long way, however, in terms of digitalization we aren’t there yet. However, as stated in Document K, SALAR together with Inera and Kommentus are on a good way of bringing the members closer together when using coordinated digital services. The following quote is from S.Z. who describes the cooperation in the context of digitalization.

"I think that one aspect that has been fantastic during these years and has come a long way, is that these forms of cooperation allow us, at all, to have counties, municipalities and regions to cooperate and have joint action plans and joint funding. Common goals and actions and like that. There I think we have come a great long way. Then it is still the case that it is fragmented in terms of the use of digital services."

-Vice President S.Z., 2018. (Authors translation)

Furthermore, when discussing the challenges and opportunities of healthcare, one aspect of digitalization that was brought up were the asynchronous communication. This communication was brought up as a change in how the patient reach the healthcare professionals, how they, for example, now can chat with their doctor asynchronously (P.S., B.W. and L.G.). Supposedly, this kind of technology is not considered high-tech, however, it provides potential to coordinate healthcare professionals around the patient in a new and more effective way, both in terms of costs and care quality (P.S). This asynchronous communication was also described as used internally at SALAR as a digital communication platform:
"[…] We can be a node to spread knowledge and experience and good examples. Connect others who are interested to be there, we created […] a collaborative platform called ‘Share Digital’ that is aimed at the public sector where local municipalities, county councils and government agencies can go online and either sharing the good one does, guidance for development work, but it is also a kind of crowdfunding-site where you can share if you are interested to do this in this area which need funding."

-Program supervisor E-Health P.S., 2018. (Authors translation)

Furthermore, on SALAR’s website the common objective of the Swedish health healthcare is Vision E-health 2025 and can be used as an example of illustrating a common objective. This objective is also mentioned in several of our documents (Doc A; Doc D; Doc E; Doc F and Doc M).

“Work on e-health is taking place together with municipalities, county councils, regions, Inera AB and in close collaboration with several other actors.”

-SALAR Website, 2018. (Authors translation)

4.3.2 Interest-conflicts

Amongst our informants, SALAR is described as an interest organization that is politically governed (A.F. and P.S.) and consists of both formal and informal groupings (P.S. and S.Z.). Furthermore, SALAR’s ownership structure is also described as complex (S.Z.). Variation in routines and operations amongst members are frequently brought up and that members seek uniformity in several areas of interest (E.S.; M.J. and P.S). For example, program supervisor P.S. at SALAR describe their work as follows:

“Since we are an interest organization, we can see that we are politically governed every day, we have a kind of miniature-parliament here when we meet, our political panels and political boards, and at that level create consensus, common priorities and so on, to make decisions.”

-Program supervisor E-Health P.S., 2018. (Authors translation)

Consensus and common priorities is frequently brought up in interviews with informants both at SALAR and at one of its member-organization, and a document (L.K.; A.R.; M.J.; A.F. and Doc O). An example of the nature of how this is achieved were explained by county manager
A.F. from Södermanland County and a frequent attendee at SALAR’s activities. The informant’s description highlights the balance between interests and demands:

“It’s quite difficult assignments that the organization [SALAR] has, it must be a party to the government and all trade unions and our county councils, and there you try to balance, based on what everyone demands and wishes, like you see yourself, all wishes, and demands are not similar. […] SALAR is like EU, which has to compromise all the time, some things you like and some things you like less, it’s not very strange.”
- County manager A.F., 2018. (Authors translation)

“Agreements which are based on a common vision and developed in consensus between the counties and the State regarding the challenges can become powerful tools to meet the challenges ahead. Agreements must be taken forward in dialogue and based on a common understanding of the challenges we face.”
- Document O, p. 65 2018. (Authors translation)

According to Document M there is broad consensus in what the challenges are in Swedish healthcare, amongst actors in the sector. However, to arrive at consensus is described as something difficult and time-consuming in collaboration and coordinating activities (S.Z. and Doc L). Furthermore, vice President S.Z. of Inera AB explains the formal structure of this “balance” that A.R. mentions. The ownership structure can be exemplified by:

“Then they had to enter on the same premises as the county councils, so that the Stockholm County Council owns as many shares as Hörby municipality, so it's all have three shares I think it is or five or something like that, nonetheless they are all the same. […] SALAR is the principal owner but they have also stated that they will not exercise their main ownership and will not go against the other owners in any matter.”
- Vice President S.Z., 2018. (Authors translation)

The ownership structure of the subsidiary is described at Inera AB’s website where it is stated that from year 2017, about 200 local municipalities have entered as shareholders. However, an updated number of 275 out of 290 has joined was brought up by S.Z.
“In March 2017, Sweden’s municipalities and county councils, SALAR, became Inera’s principal owners. Thus, the mandate of the Inera was extended to include the areas of activity of the municipalities. The aim is to increase the tempo of digitalization by reusing Inera skills and broadening the service offering of Inera’s. The individual municipalities are also offered to become a partner in Inera. In autumn 2017, more than 200 of the country’s municipalities have joined as co-owners.”

-Inera AB Website, 2018. (Authors translation)

When asked about why the municipalities take an ownership position, Inera AB’s vice president S.Z answers:

“I think they have looked at the county councils and seen our particular collaborative model that has been becoming very successful. […] There is shortage on competence, if there is shortage of funding, but if you go through a joint company instead, you can optimize resources much more.”

-Vice President S.Z., 2018. (Authors translation)

The balance between different members of SALAR is described by A.F. as related to size of the meta-organization’s members, which in SALAR is the counties and regions. A.F. points out concerns that for example Region Skåne and Region Stockholm are two large players and that their influence in decisions might be more influential than other member’s in the meta-organization.

“SALAR must beware not end up with the large county councils and regions that of Stockholm and Skåne to decide too much, without possibility for everyone to be active and come to speech.”

-County manager A.F., 2018. (Authors translation)

As pointed out before from informants and documents, SALAR’s and its members collaboration is described as containing meetings, workshops, arenas, networks and discussions (A.R.; A.F.; S.Z.; M.J.; P.S.; L.K.; Doc F; Doc K and Doc M). When members meet in these meetings, workshops, arenas, networks and discussions, one of the objectives is to discuss recommendations (A.R.; A.F.; S.Z.; M.J.; P.S. and L.K). Moreover, when we asked about the current debate about compensation systems in primary care and E-health, senior staff at SALAR described the situation as the following:
"The problem is not solved. The county councils govern because they decide on compensation systems, and we will try to produce good documentation for them to get a good discussion."

-Senior expert A.R., 2018. (Authors translation)

"We carry out surveys on different conditions in the county councils. When compiling these, differences appear that can sometimes be perceived as unjustified. The results of studies are presented to relevant groupings, for example for county councils’ financial directors, which for our part can give rise to further investigation assignments."

-Senior official L.K., 2018. (Authors translation)

The citizen-elected county official M.J. further describes this discussing which is held in these networks and meetings on the same subject of compensation systems in primary care. The aim is to achieve an agreement amongst the members on how to form these compensation systems.

"It is as if we are asking questions, we are raising questions, and that is [at SALAR] we have raised questions about these compensation systems for these digital care visits. Those, we brought to SALAR to get to an agreement of course, and the go home and decide, but it was to get something uniform."

-Citizen-elected county official M.J., 2018. (Authors translation)

Furthermore, from senior official L.K. at SALAR, discuss the variation and differing on how they provide recommendations for their members and how they are met. He concludes that before any recommendation is finished there must be a discussion with the counties, and when the recommendation is implemented they are generally followed by the counties and regions.

"On this occasion, it was possible to make a decision on the issue of the recommendation, but the matter had then been the subject of consultation among the politicians involved. I understand it as so that if it had not been consensus in advance in the matter, it had not been submitted for decision."

-Senior official L.K., 2018. (Authors translation)
S.Z. also gives an example on how they work with recommendations and what they believe is important in the reception of recommendations. S.Z also explains the process of certain decisions which is to meet and discuss matter both individually and in groups with members of SALAR.

"Then it also went out to all the county councils and regions for decisions so that each of them, it is typical that each county council must make its own independent decision, and then they send in it back to us what they have decided. [...] we managed to get everyone to stand behind it, but it was because we had shown that we had this process, with like all these suppliers and so, we had lists with who had been attending these activities. It can be time consuming but it's a part of our mission to make this anchoring work."

-Vice President S.Z., 2018. (Authors translation)

These descriptions show us that SALAR work with recommendations and guidelines for their members and that the process to complete these are time-consuming processes. The process is also described to have much to do with anchoring the content of the material in various groupings and ultimately lead to a consensus about what decision ought to be made in respective home county.
5 Discussion

The discussion is based on the conceptualized model which is presented in the end of the theoretical background. This part of the paper intends then to analyze and discuss our study’s empirical findings in relation to the theoretical background.

In our empirics, digitalization is described as something that is happening rapidly, it is a phenomenon that is dynamic and flexible in nature. To facilitate the opportunities of digitalization courage, risk-taking and iterative processes are highlighted.

The demographical development is explained as a cause to urgently increasing cost effectiveness in the Swedish healthcare sector. This empirical view of the demographic situation is much in line with previous research and statistics (Ippolito et al., 2016; SCB, 2018).

Meanwhile, we could see in our study that the decision-making processes, amongst those that provide healthcare and that are responsible for it, that is, the meta-organization’s members, are characterized as time-consuming and complex. This partly confirms previous research such as Köning, Schulte and Enders (2013), which argues that meta-organizations have slow decision-making processes.

Another way to put it is that the context that calls for decisions by the member-organizations is rapid-moving and the member-organizations themselves in their decision-making process are not rapid-moving. We will further elaborate on this tension in our discussion and we will also relate more aspects to theory about of decision-making in meta-organizations.

From what we can see from our empirical findings is that the meta-organization, one of its members and a couple of non-members, is that the healthcare sector is perceived to be under current digitalization. Previous research such as Langabeer, James and Champagne (2016), Della Mea, (2001) and Eysenbach (2001) confirms this view. According to previous research and our study, there is a great deal of e-services and digitalization which is currently changing the healthcare sector. However, in comparison to other sectors, healthcare is described as one that have not yet fully utilized digitalization. Our empirical study suggests that the Swedish healthcare are behind in its digitalization, compared to other developed countries which have come further in their digitalization of healthcare. This suggestion has not been confirmed, from what we can see, in previous research. Furthermore, otherwise highly developed in medicine and medical technology, the Swedish market actors (the meta-organization, members and non-members), believe that they have high expectations on them.
from citizens, patients and other stakeholders. These expectations are about how healthcare is delivered and accessibility to healthcare. In our empirics, other industries and usage of digital in general is often brought up in the discussions about healthcare and expectations on this sector. This empirical finding has not been discovered by us in any previous research, however, this was one of our most reoccurring themes in our study results. The expectations on digitalization and the healthcare’s utilization of it seem to be high.

If digitalization is described as a force or trend that currently putting pressure on healthcare actors and one of the most important driving factors for change, it can also be described as the solution or as a hope for increased cost effectiveness and patient safety in healthcare. Frequently, digital technology in healthcare is discussed in terms of changing the way healthcare professionals work to a more cost-effective manner. To increase cost-effectiveness is also confirmed by previous research, such as by Langabeer, James and Champagne (2016), Della Mea (2001) and Eysenbach (2001), as one of digitalization major possibilities in healthcare. From our empirical findings, this change is believed to shift more and more of the work-load from the professionals in healthcare to the patients, or users, or citizens. So, while the patients, or users, or citizens, of healthcare expect more e-health from the healthcare sector, the concept of e-health also includes the expectations on users to be more active in their care situation. None of these findings have been found by us in previous research.

In our data, thoughts about why the market actors put so much faith in digitalization was explained by the perceived need for overall increased cost effectiveness. The second environmental factor that seems to strongly influence the meta-organizations is that the healthcare sector was described as facing the current demographic development. Much of this is supported by statistics and theory outside of the scope for our study, however, when understanding meta-organization, it is important to understand the organizations’ environment. Why? Because a meta-organization is by definition an organization that organize its environment. Organizations in the e.g. healthcare sector that see each other as their surroundings can by joining the meta-organization become organized into one organization.

Back to the demographic development in Sweden, it is described as such that we have an increasing population of elderly, and relatively smaller workforce that must support the whole system, which in turn effect the tax burden. In terms of patients, or care users, we become older, live with our health situation longer, and are multi-ill and so on. All this is explained as making the care of this group more complex, and the group then demands much
of healthcare’s resources. The demographic development is then perceived as a challenge that ultimately demand the healthcare system to use its resources more effectively.

According to key persons and key documents, the current demographic challenge and digitalization was explained as like the reasons why to organize themselves in what can be theoretically defined as a meta-organization. According to literature in the field, such as Ahrne and Brunsson (2005; 2008), Rajwani, Lawton and Phillips (2015), Berkowihtz and Bor (2018), Berkowitz and Dumez (2016), uncertainty and challenges in the environment is key in understanding a meta-organization’s purpose, or vision. According to both previous research and our study shows that this is of importance when the potential member-organizations choose to join the meta-organization, or if already in it, considering leaving it. The member-organizations must balance the benefits from joining the meta-organization or stay in it, with the costs of joining or being a part of it. Ultimately, from theory, our understanding is that the membership is decided by the possibility to change the environment. Form our empirical case study, we can see that the much of the dilemmas and calls for decisions the member-organizations has is about digitalization in healthcare, demographical development and the perceived mismatch between those and that of the current Swedish healthcare sector.

To organize is a broad term, however, in our study we focus on the main elements of a meta-organization and its decision-making processes, and that is coordination, collaboration, interest-conflicts, members and non-members. From our conceptual model we see these elements as much having to do with decision-making processes in meta-organization. So, from this perspective, how the meta-organization look like in terms of these elements is about what they provide its member-organizations in their decision-making and why is it important for the members.

Firstly, if we look at coordination, we can see that how to coordinate various activities within the meta-organization and with its members is perceived important. We can also see that these activities are not always reserved for the meta-organization and its members but also to its non-members. Examples of various activities are networks, conferences and workshops. To these activities, the invitation can be either open or closed, being open means that almost anyone can attend, the meta-organizations employees, member-organizations representatives and non-member representatives (e.g. trade unions, authorities or government). Closed invitations mean that the meta-organization has selected a few key actors with which they would like to discuss some specific topics. For example, it can be these
digital care givers that politically and medially been given a lot of attention, or branch organizations that represent certain professions.

These just mentioned activities are also perceived important for the collaboration amongst the meta-organization, it members but also its non-members. The nature of this collaboration can be of both formal and informal characters. The activities such as networks, workshop and conferences, we believe in concordance with some key informants that these can be described as informal. These informal activities are frequent occurred (i.e. weekly, monthly, semi-annually etc.) but are not part of the formal organizational structure. Furthermore, these informal activities are not mandatory to attend and which individuals that attend varies. Nonetheless, these activities are perceived as important and as a foundation for knowledge sharing, best practice sharing, grounds for common priorities and values. The formal activities were more structured and had stated lines of communication, for example, one group of representatives from the members and the meta-organization prepare much of the issues to be discussed or decided upon on by the board of directors in one of the meta-organizations and its members jointly owned subsidiary. Furthermore, much of the formal activities were connected to the meta-organizations legal relationships with, or its ownership of, its subsidiary. For example, the subsidiary has historically been owned by some of the member-organizations, now the meta-organization itself has entered as majority owner (but has stated that it will be passive as owner), and more interestingly for us, the ownership structure has been broadened to include all the member-organizations of the meta-organization. One arguments in our empirical study for this, have been that the subsidiary that initially has been specialized in E-health, will broaden its operations to include all the welfare issues the member-organizations have, and not only healthcare. Yet another argument is that the second ownership wave with almost 290 local municipalities had it motives in these coordination and collaboration efforts that have been perceived as successful.

Secondly, much of our empirical findings describe the dynamics of decision-making process in terms of reaching common interests, goals and priorities. In general, from our study we can see that the coordination and collaboration activities, both formal and informal, are motivated by the aim of increasing consensus amongst members, non-members and the meta-organization. From our empirical study, we can see that consensus is the absolute strongest finding. This is discussed in previous research, where there are contradicting arguments that decisions aren’t made based on consensus (Karlberg and Jacobsson, 2015), or that decisions
are made based on consensus in meta-organizations (König, Schulte and Enders, 2013; Ahrne and Brunsson, 2008; Berkowihtz and Bor, 2018).

Consensus can be described using many synonymous terms, one often most reoccurring is uniformity. In our empirical findings, one of the major challenges with digitalization and demographic development is that it is perceived to increase the need for homogenous routines, standards, compensation systems etc. Different members are reported to have different interests at times and different priorities. Differing interest, or priorities, or interest-conflicts, have been reported in previous research such as by Heine and Kerk (2017) and Berkowihtz and Bor (2018).

Uniformity was one reoccurring theme in both our interviews, podcasts and documents. Members and non-members seem to call for uniformity in standards, routines, policies, user manuals to medical records and decision support systems. This uniformity is also seen as one of the aims for the coordination and collaboration activities that the meta-organization provide.

Furthermore, in line with increasing consensus, the meta-organizations also seem to be expected by its members and non-members to provide recommendations and by its members; documented materials for discussion. The terms governance or knowledge management is not commonly used by the meta-organization itself. However, what we can see and from our understanding of the member-organizations expectations on the meta-organization (both from one of the members but also the experience of informants at the meta-organization) is that the members forfeit a part of their decision-making process to the meta-organization and expect to receive knowledge and recommendations on how to best decide for themselves. Put differently, they are asking the meta-organization to direct them by knowledge management. However, through all the formal and informal coordination and collaboration activities, the members are still able to influence the content of the decision-making process.

To end our discussions, in our empirical findings, we can see that the coordination and collaboration of and around activities, is a significant part of what a meta-organization is all about. Coordination, collaboration and to overcome interest-conflicts is to reach consensus. Furthermore, we can see that these activities have much about how a meta-organization is organized, that is the organization is formed by these activities. However, when we looked at consensus in the meta-organization this element is seemed more about what the meta-organization is trying to achieve with this organizing. Member-organizations then see its membership in the meta-organizations as means to reach consensus and base their decisions
on a common decision-making process. So, we asked ourselves, why do the meta-organization coordinate their efforts? And our theoretically founded and empirically studied answer would then be; to reach consensus!
6 Conclusion

Our case study of the Swedish Association of Local Authorities and Regions (SALAR) and how they operate in the context of digitalization of the Swedish healthcare sector set out to answer the following research question as guidance: What do a meta-organization provide for its members in their decision-making processes and why is a meta-organization’s activities perceived as important?

To conclude our study and answer our research question, we can comment on some aspects of our case meta-organization, its members and non-members and their decision-making processes. One of the issues in the decision-making process is the, at times, conflicting interests, different prioritizations amongst member-organizations and complexity of the whole meta-organization and its decision-making processes. This is much aligned with the theory, or previous research, of both decision-making processes and the elements previously studied about meta-organizations. However, to deal with these issues, coordination and collaboration activities seems to be of importance in meta-organizational decision-making processes, to reach consensus. In the context of digitalization of healthcare, and demographical development, our study describes coordination and collaboration as what and how a meta-organization do in terms of decision-making processes. Our main empirical finding is the consensus-building, which is one dichotomic issue in previous research, Karlberg and Jacobsson (2015) opposed by König, Schulte and Enders (2013), Ahrne and Brunsson (2008) and Berkowihtz and Bor, (2018). Because of contrasting characteristics of a rapid-moving digitalization and a slow-moving healthcare, the purpose, or the why, of a meta-organization seem to be to reach consensus amongst its members. Thus, to reach consensus amongst the member-organizations is the overall purpose of a meta-organizations decision-making processes that we can report empirically and as an addition of previous theory.

6.1 Theoretical contribution

We can see that the decision-making processes in meta-organization is complex because of its members conflicting interest and often different priorities. This confirms previous research about meta-organizations and decision-making. Furthermore, both in literature and our case study we could see that meta-organizations often struggle with balancing the strong influence some members may have due to their relative size to other members. What both theory and our empirics shows us is also that decision-making processes in meta-organizations is about
facing common environmental challenges. An addition to theory, is that we confirm previous research that most of the decisions seems to be based in anchored decision-making processes and on consensus. This confirmation then leads to us rejecting previous research saying that most decisions in meta-organizations aren’t based on consensus.

6.2 Practical implications

To practitioners, we would like to give the following recommendation. Activities such as networks, workshops, conferences and day meetings, that is all the informal groupings, seems be of great importance to align interests and priorities, ultimately reaching common ground and consensus for final decisions amongst the member-organizations. However, it is not only the informal groupings that seem to matter, also all the formal groupings and ownership structure are brought up as an important aspect when trying to reach consensus. Balancing influence from larger members and involving non-members in the decision-making process also seem to be an important task of the meta-organization.

6.3 Future research

Our data acknowledge that digitalization and demographic development will be a part of Swedish healthcare now and in the future. We have briefly studied the calls for decision, and focused on the decision-making process, however, we haven’t studied the actual and final decision that are made in the member- and non-member-organizations. How these decisions are implemented and the quality in terms outcome of the decisions haven’t been studied by us. Therefore, we believe that this could be interesting for future research.

Furthermore, more interesting areas of research that emerged from the empirical data that we didn’t study were meta-organizational leadership, meta-organizational change processes and meta-organizational ownership structures.

Related to healthcare and digitalization, but no exclusive for meta-organizations, our empirical findings showed us that the time and space aspects of digitalization versus characteristics of the healthcare profession (e.g. strong profession, inapt to change).
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Appendix

Topic guide for interviews

Both you and your organization can be completely anonymous in recognition of our work. You also can take part in our transcript of this interview, approve it, and leave feedback with additional comments, before we publish our work. These are the main topics we want to discuss with you, however, we would like to be given the opportunity to ask follow-up questions during the interview.

Can you tell us a little about your work and what you do?

What is your opinion about digitalization in Swedish healthcare?

How do you see the role of county councils and municipalities and their situation of digitization in healthcare?

How do you see the role and situation of SALAR when it comes to digitalization of healthcare?

When it comes to these areas, how do you work and what is important and challenges?

How do you see the future in terms of digitization in healthcare?

Thanks for your participation