LUND UNIVERSITY

Archive number: 14518

School of Economics and Management
Department of Business Administration

FEKP90
Business Administration-
Degree Project Master of Science in Business and Economics

Spring term of 2011

Contrasting perspectives in a hospital merger: The case of the SUS eye clinic

Authors:
Erik Alexandersson & Björn Sundqvist

Supervisor:
Gudbjörg Erlingsdóttir

Title: Contrasting perspectives in a hospital merger: The case of the SUS eye clinic

Seminar date: May 23rd, 2011

Course: Master thesis in business administration, 30 University Credit Points (30 ECTS).

Authors: Alexandersson, Erik; Sundqvist, Björn

Advisor: Erlingsdóttir, Gudbjörg

Five key words: efficiency, hospital, merger, change, management

Purpose: The purpose of this study is to increase the understanding for if, and how, different views on efficiency and effectiveness characterized the organisation of the eye clinic in the SUS hospital merger. What presumptions operative efficiencies affected hospital management's merger decision? What were the expected benefits and what kind of organisational structure would help to achieve these? Finally, did different views on efficiencies affect how groups of individuals believe that the transformation should be carried out? In order to satisfy this purpose, we formulated three constituent objectives for research:

(1) How do doctors and managers believe efficiency is and/or should be measured?
(2) What do they think is efficient in an organisational change process, such as the SUS hospital merger?
(3) What do they believe is efficient in a doctor's daily work?

Methodology: This is a qualitative study where we have adopted an abductive study approach, with an interpretivist/constructivist positioning. Thus we have not tried to identify the absolute truth. Instead we have tried to identify, evaluate and describe the different individuals' views and perspectives on various aspects.

Theoretical perspectives: The theoretical perspectives cover professions and professional bureaucracies, the definitions of effectiveness, efficiency and related concepts, optimal hospital size, quality of care, organisational change and management and merger theory.

Empirical foundation: We conducted interviews with six managers from different levels of the vertical hierarchy of the SUS hospital, and eight clinical doctors with different backgrounds and current responsibilities, all working at the Eye clinic. We created and followed a semi-structured interview guide that we used to interview both managers and doctors. During the interviews we focused on open-ended questions that would bring the interviewees to freely express their views on the subject.

Conclusions: In response to our research objectives we can conclude that; there is little agreement as to how measurements in healthcare in general, and the SUS hospital in particular, should be defined; there are different views on how to manage organisational change between managers and doctors, where management prefer a top-down approach while doctors believe that they should have more say in how the change is carried out; doctor's stress the need for customized IT-support, stricter job specialisation, clear patient processes and the possibility to form informal networks and knowledge clusters. It appears that management has a narrow view of what doctor's feel is necessary for improving efficiency in their daily work since many of these efficiencies have been impaired as a result of the top-down managed merger.

In sum, it seems that our initial impression, that different views on efficiencies may cause problems in change processes, still poses a viable correlation between these aspects.

Contents

List of terms and abbreviations

UMAS – University Hospital of Malmö
USIL – University Hospital of Lund
SUS – Skåne University Hospital
PROLUMA – Process preceding SUS merger. An initiative to investigate the operations of highly specialized care at the hospitals in Lund and Malmö in order to merge some functions, encourage cooperation between units and profile the hospitals' production of highly specialised health care.
Kömiljarden – Health care bonus in place in Sweden granting additional funds to hospitals/units managing to shorten or eliminate patient queues.
Vårdgarantin – Health care guarantee set in place in Sweden to make sure all patient referrals are attended within three months.
PASiS – IT-system, primary patient- and OP- planning system, used by nurses
Melior – IT-system, primary patient journal handling by doctors and nurses
ATD – Consultancy firm hired by Region Skåne to advise on efficiency development
McKinsey – Consultancy firm hired by Region Skåne to advise on merger process preparations
DRG – Diagnostics Related Groups, weighted values of resources required for treatment of patients. Used for determining financing and measuring in the health care system.
ICU – Intensive care unit of a hospital
Cataract – Malady of the eye related to ageing, clouding of the crystalline lens causing less light to enter the eye.
Glaucoma – Malady of the eye where the optic nerve suffers damage. It may cause bleeding in the eye and is related to diabetes patients.

I – Background

1.1 History

1.1.1 Healthcare management

Healthcare in Sweden, and other countries in Europe, has been in a state of significant change for the past few decades (Choi, 2011; Ahgren, 2008; Olafsson, 2008). Rising costs of care require more and more attention, both due to a real price increase on the supply side and an ageing population on the demand side (OECD, 2003). Consequently hospitals seek to further improve their efficiency and effectiveness. The technical and medical development of what is possible to provide has also increased. However, society's access to resources increases relatively less than the demand for health care and its technical development. Hence, there exists a gap between what is medically and technologically possible, a gap that is likely to grow (Hallin & Siverbo, 2003; Elmqvist, 2002).

In Sweden, Europe and North America hospital mergers have become increasingly common and it is a universally accepted norm among policy makers for increasing efficiency, reducing costs and improving quality of care. Despite this the outcomes of hospital mergers have not been systematically evaluated (Weil, 2010; Ahgren, 2008; Aiken & Sloane, 2002). Another concern is to concentrate specialities in order to offset the loss of competent personnel due to massive retirements in the years to come (Arbetsförmedlingen, 2010; Region Skåne, 2009g). Due to the financial impact of healthcare in Sweden, this public professional service has attracted much attention from media and politics. Recent mergers include the 1997 merger of Mölndal, Östra Sjukhuset and Sahlgrenska in Gothenburg (Sahlgrenska.se) and the merger of Huddinge and Karolinska in Stockholm in 2004 (karolinska.se). However, the most recent one is the merger of the university hospitals in Lund (USiL) and Malmö (UMAS), to form Skåne University Hospital (SUS), effectuated in January 2010 (Region Skåne, 2011). These three compose the biggest trio of hospitals in Sweden. While the notions of economies of scale, efficiency and "Lean" operations has gained support and followers, critics question the applicability of these in a public professional service setting. The reason being that most models have been developed based on private sector manufacturing settings (Bringselius, 2008). Furthermore, the existing models on optimal hospital size seem to indicate that the current size of SUS is much too large (Posnett, 2002). Recent studies of the previous mergers in Sweden also reveal that the expected benefits are not realised and that hospital mergers are not always appropriate (Choi, 2011; Olafsson, 2008).

1.1.2 Lund and Malmö Hospitals

The history of the University Hospital in Lund, USiL (Universitetssjukhuset i Lund) begins in 1768 as one of Sweden's first hospitals and it was confirmed as a university hospital in 1993 (Region Skåne, 2011). Before the fusion the hospital had a work force of 7 700 and 980 permanent patient beds. The budget for 2006 was 5.4 billion Swedish crowns (SEK) (Region Skåne, 2007). The University Hospital in Malmö, UMAS (Universitetssjukhuset MAS, Malmös Allmänna Sjukhus) was founded in 1896 and redefined as a University hospital in 1994 (Region Skåne, 2011). Together with UMAS almost 5 000 employees, almost 840 patient beds, and a budget of 4.7 billion SEK in, as of 2007, (Region Skåne, 2009f) the merged SUS encompasses 12 500 employees, 1 750 permanent patient beds and 10 billion SEK in budget 2010-2011(Region Skåne, 2011). The combined hospital SUS will provide care to an area encompassing 1.7 million citizens (Region Skåne, 2011).

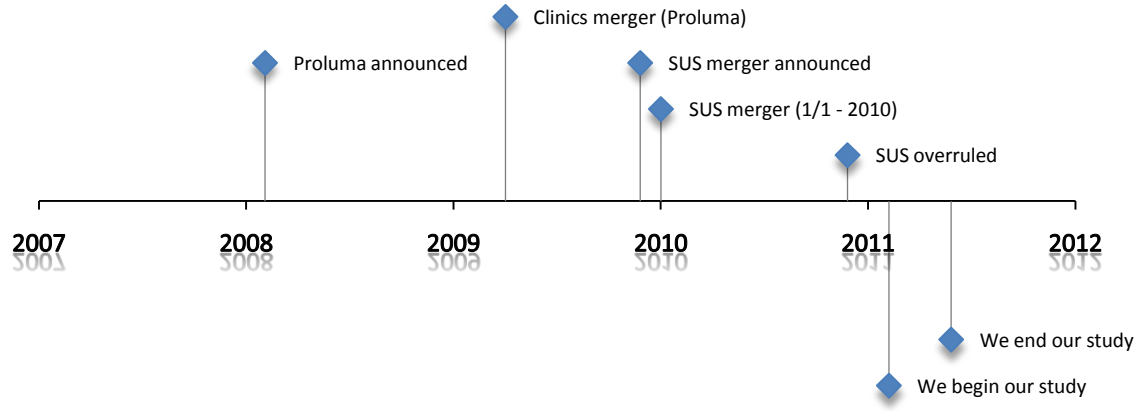
1.1.3 The Merger Process

Work with the merger started officially in 2008 with the decision to engage in a profiling exercise (PROLUMA) to determine areas of potential benefits from merging parts of, or whole, units of the

two hospitals (skane.se/proluma). A preliminary round of merging certain clinics started in 2008, with the mission to merge highly specialized care clinics' inpatient ward units and on-call duty. At the end of 2009 a decision was taken to merge the two hospitals, which was officially implemented on January 1st 2010. Reasons for the merger, similar to those claimed in previous mergers, were to utilize the collective resources of the two hospitals in matters of healthcare, education and research, in the best possible way for patients today and in the future and, thus, improve competitiveness on a national and international market. Secondary goals include improving the attractiveness of employment at the hospital, create further opportunities for clinical research and achieve critical volumes for clinical operations and competence- and research development (Region Skåne, 2010b).

The merger has featured in media frequently the last year (e.g. Skanskan.se; Sydsvenskan.se), especially pertaining to employees' loss of sense of job security, confidence in the organisation's leadership and a resulting loss of employees. The merger was also opposed in the Swedish administrative court (Förvaltningsrätten) on grounds of not being announced in the correct way, impairing the formation of public opinion and the political process (Sydsvenskan, 2010). In particular the Eye clinic has been singled out as having encountered several problems in the merger process. These include personnel resistance, loss of competence, lengthening patient queues and reduced productivity, especially with corneal- and cataract surgery where some patients have been sent to other hospitals for treatment (Skånska dagbladet, 2011b). The decision to concentrate several units of the clinic to Malmö, such as retinal surgery, was met with particular resistance among personnel.

Timeline of Proluma and SUS events



1.2 The complexity of a hospital merger

In 2008 the PROLUMA project was announced by Region Skåne in southern Sweden. It contained plans for merging 14 pairs of clinics belonging to the Lund and Malmö university hospitals. Some of the clinics protested against the way in which the clinics were supposed to be merged and how the management and the highly specialized care would be concentrated to one of the hospitals in each pair of merging clinics. The most cited clinic in the Swedish newspapers was the eye clinic in Lund where the doctors did not agree that management and large parts of the operations should be concentrated to Malmö. After the clinic-merger announcement there has been a significant loss of competence due to voluntary resignations.

As a response to the recent developments within public healthcare, with rising costs of care without a real possibility for increased funding, hospitals must develop their operations to work more effectively and efficiently. However, hospitals are very complex organisations directed by three main groups of actors: doctors, administrators and politicians. These are influenced by their respective backgrounds and positions and their ideas about how to best manage health care organisations are not always coinciding with each other (L. Axelsson, 2000; Hallin & Siverbo, 2003; Elmqvist, 2002). In response to this, L. Axelsson & Kullén Engström (2000) assert that:

> *"The basis for successful development of the organization's activities is probably a unanimous interpretation of the concept of effectiveness. It may then be expected that different decision levels will work in the same direction. Since business development is partly the relationship between objective and results, it is important to develop relevant measures in order to determine if goal fulfilment has been achieved."(p.9)*

Health care authors have called for an increased research on hospital mergers (Choi, 2011) and argue that most mergers fall short due to managers lacking the necessary understanding and appreciation of the differences in culture, values and goals of the existing organisation (Weil, 2010). There is a need for increased effectiveness and efficiency, and room for improvement is big within several areas such as the operational business, prioritisations and output control (Elmqvist, 2002; Hallin & Siverbo, 2003). After studying a major Swedish hospital merger in Stockholm, Choi draws the conclusion that:

> *"A true understanding of the intra- and inter dynamics inherent in a context with multiple layers of competing institutional logics, such as public sector health care, seems essential to produce functional organizational outcomes." Choi (2011[1])*

Hence our ambition with this study is to try and contribute with one part of the puzzle to the understanding of the efficient and effective health care organising and change management.

Our study is based on a belief that critical areas are important to understand, both in order to be better at handling the problems that occur and to minimize their negative effects. Employee discontent, possibly increased by intense media attention, may spread to the rest of the change process in other parts of the organisation (Morris, 2008). Resignations can also have a demoralizing effect on the employees (Staw, 1980). Thus an understanding of possible critical areas is important to be able to prepare and evaluate different aspects of the merger. Hence, our study has focused on the clinic with the most negative media attention and apparent complications; the eye clinic.

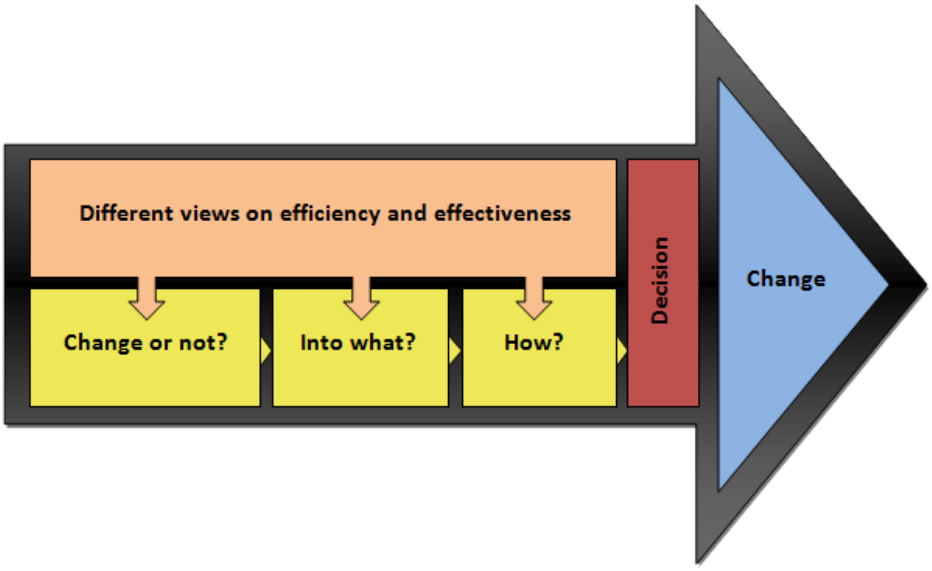
[1] This exact quotation is found in the discussion of Choi's abstract which is not paginated. It involves two aspects that she combines in the discussion. These can be found separately on page 45 and 54.

II - Purpose and objectives

2.1 Purpose

The purpose of this study is to increase the understanding for if, and how, different views on efficiency and effectiveness characterized the organisation of the eye clinic in the SUS hospital merger. We wondered what basic presumptions about operative efficiencies affected the hospital management's decision on whether to merge the two clinics or not. What were the envisaged benefits and what kind of organisational structure would help the clinic and hospital to achieve these? Finally, did different views on efficiencies affect how groups of individuals believe that the transformation should be carried out in order to ensure that the end results are truly effective? Following the reasoning mentioned above, our study focused on the investigation of these views in the eye clinic, where most problems have appeared.

The graphic below illustrates our idea of how these views on efficiencies might interrelate and affect the decision regarding if a merger is necessary, what the change should consist of, and how to realize the merger of two clinics. In the end we think that differing views on efficiencies might have an effect on the performance, cost structure and quality of care provided by clinics; and consequently an effect on the outcomes of hospitals and health care in general.



2.2 Objectives

In order to address the purpose of this study we tried to identify possible disparities between doctors' and managers' views on operational, organisational and management efficiencies. The operational efficiencies correspond to whether there is a need for change. The organisational efficiencies correspond to what needs to be changed and what the result should be. The management efficiencies correspond to how a change should be carried out in the best possible way. During the course of our study these three research questions were formulated:

(1) How do doctors and managers believe efficiency is and/or should be measured?
(2) What do they think is efficient in an organisational change process, such as a hospital merger?
(3) What do they believe is efficient in a doctor's daily work?

To answer these questions our study aimed at trying to identify the doctors' and managers' views on operational efficiency, the strategic and decision-making process, and what they believed were the

purpose and results of the merger. The interest for studying this is that if there are different views on efficiency and how to manage healthcare, any organisational change adopted will meet resistance. So, an understanding of such differences would allow managers to adapt plans accordingly. In the end, this would allow for more effective adaptations in modern healthcare which could increase overall quality and effectiveness of healthcare.

2.3 Demarcation & focus

There are some important aspects of this study that we need to delineate. We have to inform our reader that there are two processes that we will discuss. First, there is the PROLUMA process which is a county project where certain highly specialised clinics from two hospitals are merged. The second process is the SUS merger of the two entire hospitals which started almost two years after PROLUMA. For the sake of discussion we will often refer to these two processes as one process. This is because the doctors at the clinical level consider PROLUMA to be a merger. Thus, for them the SUS merger did not bring about too many new elements into the course of action. During our interviews we talked about "the merger" in general and neither we nor the doctors made any real distinction between the two processes. From the managers' side the distinction was a little clearer, but we still talked about the merger in general during the interviews. Concerning the top managers it is also important to note that their perspectives are mainly encompassing the entire hospital while the doctors' perspectives embrace the clinic.

Furthermore we are only studying two of the three major actors within health care: doctors and managers (administrators). We will not study the political aspects of health care management and the politicians' views on efficiency in health care, since we believe that merits an entire study conducted separately.

The reason why we chose to study only doctors instead of including other hospital personnel such as nurses is mainly because of the characteristics of the profession. The doctors are commonly depicted as one of three archetypes, and sometimes even the archetype, of professions (Alvesson, 2004; Freidson, 1994) while nurses are described as semi-professionals (Hallin & Siverbo, 2003). We will discuss professions further in our theory review chapter. The health care literature that we have read is mainly focusing on the doctors, who are ascribed a status as the key workers in health care (Freidson, 1975). In their role they are highly autonomous and they both define and develop the health care practices (Mintzberg, 1993). This, together with being the actual superiors of the nurses, distinguishes them from the nurses.

If we studied both doctors and nurses we believe there is a possibility that these two groups have different views on efficiency and that the scope of our study would be greatly broadened. We believe that a study on possible differences between nurses' and doctors' views on efficiency could bring about interesting results as well, but that is something we leave to others to delve into.

A final note is that we will not actively try to evaluate whether the decision to merge the clinics and hospitals was correct or not. This is because the causality between merger and outcomes might be difficult to determine over time. Also, results of the merger may be even more difficult to determine so soon after it was carried out. However, as we are studying the perspectives of the managers and doctors their ideas and opinions on the merger will be reflected in the study.

III - Methodology

3.1 The abduction approach

In qualitative research, where the focus is on how the individual perceives the surrounding reality, the study approach is mainly inductive (Backman, 2008). We have kept an open mind to the possible existence of several different theoretical aspects and have thus rather tried to identify if there are any ideas or arguments brought up in our research that can be referred to any of these. Our study was not based on any particular theoretical framework. However, as we had some broad theories in mind that we expected to be useful, and elements of which we were aware of could emerge in our study, our research contains a modicum of deduction, which is rather common in the inductive process (Bryman & Bell, 2007). It is usually referred to as abduction when moving back and forth between an inductive and deductive approach (Björklund & Paulsson, 2003). Abduction is probably the method used in real practice in many case-studies (Alvesson & Sködberg, 2009), and also in ours. It should not be seen as a mix of induction and deduction. Instead the empirical area is successfully developed and then the broader proposed pattern of theory is adjusted and refined during the research process. Compared to the other two approaches it includes understanding as well and is rather close to hermeneutics (Ibid.).

3.2 Epistemological and ontological positions

Our epistemological view is interpretivism, or more precisely: hermeneutic-phenomenology. Bryman and Bell (2007) describes interpretivism as the view where people and institutions are seen as fundamentally different from natural sciences in the way that the same scientific models cannot be applied to study the subject. Instead of a positivist view, where an explanation of human behaviour is attempted, the theories and methods used in the interpretative view are concerned with interpreting and understanding human behaviour. What is emphasized in phenomenology is that the human behaviour is to be seen as a product of how people interpret the world and therefore attempts are made to see things from the individual person's point of view (Taylor & Bogdan, 1998). The philosophy of phenomenology is concerned with how the individuals make sense of the world around them and the social scientist is thus supposed "*to gain access to people's 'common-sense thinking'*" (Bryman & Bell, 2007, p.17). The scientific value of individuals' common sense is neatly captured by the Nobel economics prize laureate Gunnar Myrdal (1969) asserting that "*science is nothing but highly sophisticated common sense*" (p.14).

Our ontological position is one of social constructivism. This approach is not particularly theory-oriented; instead the revelation of how social phenomena are socially constructed is at focus (Alvesson & Sköldberg, 2009). These phenomena are regarded as continually being produced and reproduced by social actors, through social interaction, and thus are constantly revised (Bryman & Bell, 2007). This ontological position could also be labelled "the qualitative perspective" wherein it is argued that reality is an individual, social and cultural construction (Backman, 2008).

In our study we have not tried to identify the absolute truth and we have not tried to evaluate the merger in order to determine whether it was appropriate or not. Nor have we tried to describe the cause and effects of actions or inactions. Instead we have tried to identify, evaluate and describe the different individuals' views and perspectives on various aspects. Thus we have tried to interpret how the events in the SUS merger are products of individuals' sense-making of the world around them and how they believe this reality is approached in the best way, for example through different organisational changes. We have also tried to identify discrepancies between groups of individuals belonging to vertically separated organisational positions in order to see if there are different social constructions that affect their perspectives. These positions are in our study limited to top managers, middle managers and doctors.

3.3 Procedure

In order to satisfy the objective of this study, with our interpretative and social constructivist approach, it is essential that we collect our own primary data. Secondary data will be used only in order to describe the course of events, to complement with background details when necessary, and in order to build our arguments. We conducted interviews with six managers from different levels of the vertical hierarchy. Three of them had medical backgrounds while two of them had been working several years within the health care and pharmaceutical industry but without medical education. Among the eye clinic doctors we interviewed eight individuals with different backgrounds and current responsibilities. This is discussed further below.

The managers were asked about their views on organisational efficiency as well as what they think is efficient in a doctor's daily work. They were also asked "how do you believe that doctor's perceive efficiency?" The aim with this last question was to see if the managers believe they have differing views due to their different organisational positions and professional status. It would potentially give us an indication as to whether they believe perspectives on efficiency can differ depending on different socially constructed realities adhering to various organisational positions. Correspondingly, we posed the same questions to the doctors to see what they thought was efficient in their own daily work and if they believed that the management had the same ideas.

All interviews were scheduled for an hour. However, the actual interviews ranged between 51 minutes and 134 minutes, with an average 78 minutes. Before the interview we briefly presented ourselves, our educational program and the purpose of the study. We also explained that we were not out to judge the merger in terms of being successful or not, but rather that we believed the context of the merger would shed light on the differing views on efficiency. We asked for permission to record the interview and informed our interviewees that their identities would be held anonymous and that they would have access to any material used from the interview before publication. During the interview we focused on open-ended questions that would bring the interviewees to freely express their views on the subject. We were extra cautious about not mentioning any kinds of key words, or value laden words. Instead we hoped that these would be brought up by the interviewee so that any of our follow-up questions used wordings previously brought up by the interviewee. However, in some cases we felt the need to use a certain term when clarification was needed.

We created and followed a semi-structured interview guide (enclosed in Appendix I) that we used to interview both managers and doctors. In some cases our questions were rendered obsolete during the course of the discussion, while some answers merited further and probing and questioning. Furthermore, as we proceeded with our interviews new questions arose. Thus, some questions were added during the course of the study, based on previous interviews. When interviewing the managers the additional questions were quite similar to those on our initial guide. When interviewing the doctors we added some questions based on the discussions with the managers and these have been accounted for below the headline "Additional questions to the doctors" in the same appendix (Appendix I).

The interviews were conducted in Swedish and the extracts we have used in our paper were translated into English by ourselves with careful consideration to the reproduction of the same sense and context as expressed by our interviewees. Hence, we have tried to convey their point of view as realistically as possible, rather than focus on language correctness. Consequently, some quotes may contain certain grammatical irregularities and manners of speech, expressions and, to some extent, 'Swenglish' adaptations. In the same way we have translated the citations from secondary material ourselves as many of these have been in Swedish.

3.4 Primary data collection

3.4.1 Choice of clinic

Our interest for this study emerged when we heard about the merger between the Lund and Malmö university hospitals. We decided to focus on one clinic in order to limit our scope and the choice of studying the eye clinic came naturally for several reasons. It was not the only clinic that had severe problems, but it was the one that was most frequently discussed in newspapers, on the internet and by those we heard talking about the merger. We considered this to be good characteristics of a field study as the effects, disparities and other events would be more salient and thus easier to observe. It was also the clinic that we, through a contact's contact, could get access to a first informal conversation that helped us understand some of the major events and establish our research questions.

In addition to these reasons we believe that the most critical areas within a change process deserves extra attention. Our hopes are thus that our study can contribute to a better understanding of this case in particular that might be useful both in its future process but also for other similar envisaged processes. We believe that identifying where not to push the change through so forcefully, or assigning these critical areas extra resources, might be ways in which processes dependent on organisational-specific contingencies can increase their chances of success. In the selection of individuals we have chosen to delimit ourselves to a group of managers on the one hand, and a group of doctors working at the eye clinic on the other.

3.4.2 Selection of individuals: managers

We conducted our interviews during the spring of 2011 and we started off by contacting and interviewing the management. We contacted strategically chosen managers either with a direct connection to the eye clinic, or with a good insight in and/or responsibility for the hospitals and the Proluma and SUS merger processes. Out of nine people contacted two referred us to another person, two did not answer and six accepted to be interviewed. We have divided the managers into two groups: top managers and middle managers. One of the managers interviewed was the Region Director who is referred to as either the Region Director or a top manager depending on the importance of pointing out his special role in the merger process as the premier initiator.

3.4.3 Selection of individuals: doctors

We contacted the doctors in two different ways. First, from an initial contact at the eye clinic we received a list of names of current and previously employed doctors at both Malmö and Lund. From this list we chose a number of individuals to contact based on the prerequisite that they had worked from before the PROLUMA process until after the SUS merger commenced. Secondly there was a manager who gave us the contact information to a number of doctors from both Malmö and Lund that we contacted. Thus we have tried to reach a good mix of doctors from both sites and through different contacts. In total we interviewed eight eye clinic doctors. Something we saw as a possible problem was that we would risk talking to individuals within one or two specific group of friends or close colleagues who in a way have become homogenized through discussions at lunch etc. This could, for example, lead to ideas or the use of words of one colleague having spread to the other colleagues. On the other hand, this is a reality of any workplace consisting of a group of like-minded individuals.

3.5 Secondary sources

The secondary sources used are mainly documents from the SUS web page (www.skane.se/sus) and the documented information on the Proluma web page (skane.se/proluma). This involves mail

correspondence, mission statements and reports. In the cases where documents were accessed in Swedish relevant excerpts have been translated to English in text.

IV - Literature review

4.1 Hospital size – bigger is better?

There is a common conviction among Swedish policy makers that bigger hospitals lead to lower average costs and an improved clinical outcome even if the effects of hospital mergers have not been systematically evaluated (Ahgren, 2008). Between the years 1980 and 2008 the emergency care hospitals with consistent and coherent management have decreased from 118 to 54, partly due to mergers (Ibid.). The optimal hospital size is dependent on patient accessibility, specialised care that requires a certain volume to ensure positive patient outcomes, and possible economies of scale (Posnett, 2002). Lowering average costs by increasing hospital size presumes that the organisation can profit from economies of scale which is a situation in which large-volume operations result in lower unit costs (Thompson, Strickland & Gamble, 2007). It can allow *some* firms to gain competitive cost advantages over others and is most likely to occur in capital-intensive industries such as factories and assembly line production. In contrast, it is less likely to occur in labour intensive industries, although there are examples of it (Besanko et al., 2010). However, for different reasons these economies of scale are not unlimited. Beyond a certain size bigger is no longer better and diseconomies of scale may arise, where the unit cost increases again and might even exceed its initial level (Morris et al., 2007; Besanko et al., 2010).

After an extensive summary of a large number of studies Posnett (2002) found "*remarkably consistent*" (p. 103) results indicating that diseconomies of scale existed below 300 beds and above 600 beds. The studies gave inconsistent indications as to what the actual optimal size would be, but they suggested it to be within this range. Harris, Ozgen & Ozcan (2000) found that mergers do affect hospitals' scale efficiency but that they do not affect their technical efficiency (defined as the relation between input and output). However, the findings were not statistically significant and the hospitals were summed together and compared to each other in total number of beds. The average number of beds per merged hospital was 399 pre-merger and 378 post-merger. This means that the average number of hospital beds in their study was 200 or less since some mergers consisted of more than two hospitals. The Lund and Malmö hospitals used to have 980 and 840 respectively (equals 1820 pre-merger) while today the post-merger number of beds is 1 750 (Region Skåne, 2011). Studies on the economy of scale of hospitals in this category of size seem to be rare. Hospital employees in other Swedish hospital mergers have been found not to believe in any quality improvement or generated economies of scale (Rosengren et al., 1999; Ahgren, 2008; Olafsson, 2008).

Another concept that indicates favourable competitive advantages through size is the learning curve, where cost advantages are achieved through accumulated experience and know-how. This implies that if learning possibilities exists and the output is increased then unit costs will increase in the short run but eventually decrease in the long run as the organisation accumulates more knowledge about the production. This is mostly studied in relation to costs but it can be applied to quality of care as well where a doctor treating a higher number of patients accumulate more experience (Besanko et al., 2010).

Boston Consulting Group has preached aggressive growth in order to exploit these learning advantages (Besanko et al., 2010). However, the underlying principles should not be forgotten since these unit cost reductions to a large extent are dependent on the organisational learning that has taken place during the time the output volume was increased. Thus, these benefits are primarily achieved through organic growth and not when the production is increased through mergers (Alarik, 1982). Another underlying principle is that this experience is accumulated in the beginning of the product life cycle and that the "learning curve slope" eventually flattens out (Besanko et al., 2010). In correspondence to health care one could say that, for an inexperienced doctor the increase in output will lead to an increase in unit cost in the short run but lower unit costs in the long run. For an

experienced doctor, however, the short run unit costs will increase in the same way but the same advantages will not be achieved in the long term. Managers who cannot separate the benefits from economies of scale and the learning curve may draw the wrong conclusions regarding organisational size. If the low unit costs are a result of the learning curve an increase in size might not be favourable and vice versa (Besanko et al., 2010).

Although the appeal of 'bigger is better' in hospital mergers is powerful, the empirical evidence is clearly weak for positive outcomes while significant for negative outcomes (Canadian Health Services Research Foundation, 2004). Despite theoretical economies of scale almost all studies (principally in Canada, Norway, Sweden and the UK)suggest that hospital consolidations raise costs of care by at least 2 %, while in the US this number is sometimes significantly higher (Weil, 2010). According to Alarik (1982) there are several possible explanations to why economies of scale fail to occur in horizontal fusions. One of those is that the basic business idea is incomplete and not easily replaced solely by a change in size. Fusions have increasingly become a defensive strategy against poor profitability where size is seen as the decisive factor for efficiency. The faith in the success of these mergers is very strong and they have become some sort of panacea against bad profitability (Alarik, 1982). Related to hospitals this concern is voiced expressively in a recent study by Thomas Weil, author of '*Hospital mergers: a panacea?*' (Weil, 2010). Posnett (2002) concludes that cost cannot generally be presumed to be lower or outcomes better in large hospitals. "*The determinants of patient outcome are poorly understood, and the emphasis on volume as a proxy for the skill and experience of individual clinicians is probably misplaced*" (p. 114).

4.2 Quality of care

In his book *An Introduction to Quality Assurance in Health Care* Donabedian (2003) defines quality of care as a product of two factors. Firstly the science and technology of health care and secondly the application of that science and technology in actual practice. He writes that that product can be characterized by several attributes that include efficacy, effectiveness, efficiency, optimality as well as acceptability, legitimacy and equity. Individually, or in combination, he argues that these can define and measure the magnitude of quality. This is a non-comprehensive list that can be both broadened and more detailed. Morris et al. (2007) make further categorizations of equity, defined as the fair distribution of health care in society, including aspects that are partly overlapping the attribute legitimacy described by Donabedian (2003).

We will not delve into these aspects of acceptability (conformity to the wishes, desires, and expectations of patients and their families), equity (fairness) and legitimacy (conformity to social values, norms, laws etc). Instead we limit ourselves to describing efficacy, effectiveness, efficiency and optimality since our study is mainly oriented towards studying doctors, management and hospital processes and not the actual effect on patients. Furthermore, it is possible that a sufficient level of organisational efficiency is a prerequisite for the doctors to have the extra energy needed to make an additional effort in providing services that are for the well-being of the patient but not essential for their medical treatment.

4.3 Efficacy, effectiveness and efficiency

In health care literature there is an abundance of different ways of defining what in everyday speech probably most commonly is called efficiency. Synonyms or broader/more narrow definitions of the same concepts that we have come across in the health care literature are for example: economic efficiency, cost-effectiveness (Morris et al., 2007; Hallin & Siverbo, 2003; R. Axelsson, 1998); scale and technical efficiency (Harris, Ozgen & Ozcan, 2000); adaptive and allocative efficiency, (Elmqvist, 2002; Morris et al., 2007) and '*doing the right thing*' compared to '*doing these things in the right*

way' (Hallin & Siverbo, 2003). L. Axelsson & Kullén Engström (2000) have delved more into this subject and found further concepts such as clinical, managerial, production and distribution efficiency; operational and model outcome; as well as rationalization. Further concepts such as optimality, internal and external efficiency and productivity will be addressed shortly.

4.3.1 Problems in distinguishing between the different concepts

In the academic world a certain kind of vocabulary is used in order to be accurate when discussing various subjects in detail. This is important because it avoids misunderstandings and allows for reaching higher levels of knowledge. However, in everyday life these concepts might not always be used in the exact same way. This causes a problem in two ways. First there is a problem of definition. For example the concept productivity is sometimes used as a synonym for effectiveness (Baker, 1980, in L. Axelsson & Kullén Engström, 2000). Also, since both effectiveness and efficiency are integral parts of quality of care (Donabedian, 2003) these two concepts might overlap in our coming discussions. Furthermore our study is not limited to one of these concepts and there is no one English word that completely embraces *productivity*, *effectiveness* and *efficiency* etc. Thus we hereby notify our reader that we will try to use the most appropriate concept, but when speaking generally we will predominantly use efficiency even though we might refer to closely related concepts such as effectiveness as well.

The reason to why we need to be able to speak generally about these concepts is due to our second problem: the problem of translation. Since we study a Swedish hospital merger the interviews are conducted in Swedish. In Swedish there are no equivalent words used to distinguish effectiveness, efficiency and efficacy. Instead the Swedish word "*effektivitet*" embraces all of these (L. Axelsson & Kullén Engström, 2000). There are existing words that do distinguish them partly but according to dictionaries (Norstedts engelsk-svenska ordbok, 1994) all the three concepts are translated to "*effektivitet*" while two of them are translated to "*verkan*". From this follows that the meaning and application of the efficiency concept may sometimes be inconsistent and unclear (L. Axelsson & Kullén Engström, 2000). Hence our interview questions and corresponding answers regarding "effektivitet" are not distinguishing between the different concepts. The difference is not specified by participants and we do not ask our interviewees if they are aware of the difference. Having decided how to deal with the translation problem, the question is which concept to replicate in writing. In order to reflect the interviews properly, should we use "*effectiveness*" or "*efficiency*" when we discuss our empiric material, and not distinguish any of them in particular? We will try to use them as precisely as possible when the context makes is clear which term the participant refers to, but sometimes one of them will be used generally and possibly include the meaning of other concepts as well.

Within Swedish literature this problem has been addressed by distinguishing between internal and external "*effektivitet*". However, the use of the concept is poorly defined and inconsistently used by the different authors (L. Axelsson & Kullén Engström, 2000; Alarik, 1982; R. Axelsson, 1998; Hallin & Siverbo, 2003). While R. Axelsson (1998) writes that external efficiency refers to the satisfaction of human and social needs from health care and internal efficiency as productivity Hallin & Siverbo (2003) defines external as effectiveness and internal as efficiency and productivity. Thus they define external efficiency differently and by defining '*internal efficiency*' as equaling efficiency and productivity they contradict Baker (1980, in L. Axelsson & Kullén Engström, 2000) who wrote that productivity usually is synonymous to effectiveness instead, as mentioned above.

Our conclusion is that we have to choose which author's definitions to follow. We have chosen the definitions used by Donabedian (2003) for two reasons: first, we think he explains them very well and thoroughly, and second, he is often referred to by other health literature authors discussing elements of efficiency.

4.3.2 Efficacy

According to Donabedian (2003) efficacy is the ability to use the available science and technology in the most optimal way. That is, "*the standard against which any improvement in health achieved in actual practice is to be compared*" (p. 4). It is a product of research, experience, and professional consensus. Elmqvist (2002) writes that there is a gap between what medical care is technically and economically possible to provide. Hallin & Siverbo (2003) write that this already large gap between what the health care can do, and the access to resources, is likely to increase since the technological development is more rapid than the growth of resources.

Donabedian (2003) writes that "*efficacy is the ability of the science and technology of health care to bring about improvements in health when used under the most favourable circumstances*" (p.4). Our interpretation of this is that efficacy is a measurement of how well the organisation achieves what it is supposed to achieve. A university hospital is assigned to provide more complicated and advanced medical care compared to a county hospital. Thus comparisons between how well they do based on efficiency and effectiveness might be unfair since the degree of difficulty is not the same. For example a clinic with 'worse' efficiency might actually provide a higher level of quality care due to the fact that their cases are relatively more difficult to treat (Fölster et al., 2003). Instead, efficacy may be a more relevant measure. The county hospitals' clinics are measured after the standard that they are supposed to live up to while university hospitals' clinics are measured according to the unique specialities that they are supposed to provide and the extra difficulty that involves. Hospitals could in that way be measured according to how well they make use of the scientific and technological possibilities at their disposal.

4.3.4 Effectiveness

According to L. Axelsson & Kullén Engström (2000) effectiveness includes both the level of improvement in health by provided care and how well the improvement in health matches what could be expected from optimal care. This corresponds to Donabedian's (2003) definition: "*the degree to which attainable improvements in health care are, in fact, attained*" (p. 6). It is thus an assessment of how well the reasonably expected performance is achieved. The reasonable expected performance is what health care science and technology allows for, either ideally or under specific conditions. It is important to remember that this "best" or "standard" care against which effectiveness is measured is changing over time. There should be a continuous improvement over time in most hospitals where new knowledge and technology improves the care that can be provided, thus raising the bar for what is reasonably expected. Though, in worst case scenarios different events could also lower this standard.

Other things to keep in mind according to Donabedian (2003) are that effectiveness should be seen as an 'expected average' of a larger sample. Thus individual or smaller samples of cases could have a bad or below standard outcome but the larger sample of cases, the total provided treatments of a hospital, could nevertheless be effective. It is also dependent on how one defines and measures "health", which can be a tricky business and makes the outcome of the treatment hard to evaluate in some cases.

As mentioned above there are problems of definition concerning, mainly, productivity and effectiveness. Productivity is an often used concept but it seems to be poorly defined. According to Fölster et al. (2003) productivity is calculated on the input variables only, and thus is a measurement for how well an organisation uses its resources irrespective of what it produces. This corresponds to the SOU 1997:28 definition used by Lundquist (1997, in L. Axelsson & Kullén Engström, 2000) "*that the cost of each measure must be as low as possible*" (p.3), but is in direct opposition to Elmqvist's (2002) definition of the same concept. He states that performance, in relation to costs, should have

desirable effects. Quinn & Rohrbaug (1981) asserted that no commonly accepted definition of effectiveness had emerged and that the concept had proved to be elusive. If we consider how Donabedian (2003) defines effectiveness it cannot be seen as synonymous to any of these.

4.3.5 Efficiency

The term "efficiency" is "the ability to lower the cost of care without diminishing attainable improvements in health" (Donabedian, 2003, p.9) or with a different wording: "the number of units produced for a given number of inputs" (Quinn & Rohrbaug, 1981 p.123). Improved efficiency can be achieved in two ways, either by lowering the cost relative to the care provided or by increasing the care provided relative to the cost of that care. It is not enough to lower the costs to increase efficiency since the care provided has to be either intact or improved. We would like to add to this definition that theoretically the care could in fact be decreased as well but only as long as it decreases relatively less to the decrease in costs. Though lowering care because of an increased efficiency is probably not something that would be well received by the majority of a hospital's stakeholders such as the public or politicians. In public organisations the aims of reforms are predominantly to lower costs but maintaining the same output (Hallin & Siverbo, 2003). Experiences from Swedish health care reforms show that hospitals that increased performance at the same cost succeeded initially but experienced cost escalating later on. The results have been that counties are recommended to reduce costs at maintained levels of performance (Elmqvist, 2002).

Donabedian (2003) writes that there are three efficiencies in health care: (1) Clinical efficiency: prescribing and implementing more efficient care that is dependent on knowledge, judgment and skill. (2) Managerial efficiency: The efficient production of goods and services through the application of methods such as running at higher occupancy rate, reduction of errors (and thus costs) through stricter procedures as well as task and hierarchical specialization. He points out that "without the participation and consent of clinicians, some of these changes would be difficult to introduce" (p. 10). (3)Distributional efficiency: the allocation of resources to groups of patients in proportion to the expected improvement in health. Thus resources might be prioritized to subgroups who are either sicker, more likely to benefit from the care, more likely to benefit from the care for a longer period of time, those that can be treated at a proportionately lower cost or a combination of two or more of these alternatives.

4.3.6 Relating the three concepts to each other

As we believe that these three concepts might cause some confusion and be used differently by different individuals we feel a need for a further visualization of the concepts, both in order to explain them as well as to describe our understanding of them. We have created the chart below to explain this. The basic principles are that hospital A and B have the same assignments and the same specialist clinics. That is they are supposed to be able to provide the same health care and have equal access to the nation's accumulated science and technology. The determinants of their success are thus how they make use of this through, for example, strategic organising and management.

Hospital	Cost	Cured patients	Conclusion
A B		200 / 400 100 / 200	Hospital A has a higher efficacy as it can cure more patients than hospital B. But the effectiveness is the same for both (50 %).
A B	20 50	100 / 200 100 / 200	Both hospitals are equally effective (50 %) but A has a lower resource input and is thus more efficient.
A B	20 50	100 / 200 105 / 200	Hospital B is more effective (it cures more patients than A) but resource-wise it is less efficient. With a 150 % higher resource input it only cures 5 % more patients.

The reason why we have several different ways of defining what is good performance is probably because there are different views on what is desirable. Quinn & Rohrbaug (1981) discuss how different viewpoints on effectiveness are dependent on individuals' values, hierarchical positions, type of unit and several other factors. Even if we focus on one of these concepts there will still be someone who is not happy with the result because something else is lacking. Thus, the goal with all these measurements is often to reach an optimum. This is the amount and combination of different variables which is deemed to be as perfect as possible and that most people would agree on. Optimum can be described as the point below which one can still improve and above which the benefits achieved through further input are much too costly in comparison to that benefit. The problem with optimality is that one needs perfect information, which is impossible to acquire. Hospitals are complex organisations with various groups of actors with different ambitions. This renders management more difficult, especially considering the different actors' bounded rationality, the inability to make perfect decisions due to limited information and cognitive ability (Hallin & Siverbo, 2003). With all the apparent as well as theoretical variables that must be considered, optimality is probably impossible to achieve. Even if it was achieved it would not be possible to know if it was the true optimum or if it in some way could be improved further.

In addition there are, as Donabedian (2003) points out, serious ethical implications involved in optimality. For example, how do you value a year of life gained at a certain age when comparing it to the costs of that treatment? He discusses one aspect of this which he calls "social legitimacy" or "social acceptability", referring to the disparity between individuals and collectives in their views of efficiency and optimality. Individuals are mainly concerned with what they pay and what care they receive while society is more concerned with the efficient distribution of tax money, the immunization of sufficient amounts of individuals to prevent diseases, or the longevity of certain individuals where, for example, younger individuals might receive a higher priority than the older. Morris et al. (2007) discuss different aspects of ethical imperatives, prioritising and their relation to cost-efficiency. Swedish law on how to prioritise in health care is based on a governmental investigation, '*the health care's hard decisions',* discussing ethical principles (SOU, 1995:5). Our own conclusion is that if ethical implications are involved then optimality can differ depending on who you ask. This means that effectiveness and efficiency can be viewed differently by groups of individuals with different backgrounds and in different positions (see Quinn & Rohrbaug, 1980).

4.4 Professional bureaucracies

Within healthcare literature the doctors are usually defined as professionals (Svenér, 2010; Nilsson, 1999; L. Axelsson, 2000; Olafsson, 2008). We will describe the implications of this concept and we will mainly base our literature review on the works of Mintzberg (1993) and Freidson (1975; 1994), two authors who are frequently referred to when discussing professionalism as an important aspect of health care organisations.

4.4.1 Professions and professionalism

The definition of what a profession is and how professionalism should be defined has been much debated for a long time and there is no real consensus on how to delineate the concept (Alvesson, 2004; Freidson, 1994). After a comprehensive discussion on the different connotations and denotations of the concept profession, Freidson (1994) concludes that "*all serious writers on the topic should be obliged to display to readers what they have in mind when the word is used*" (p. 27). His own definition of the word is "*an occupation that controls its own work, organized by a special set of institutions sustained in part by a particular ideology of expertise and service*" and professionalism is thus referring to "*that ideology and special set of institutions*" (p. 10).

Professions should thus be separated from the broad strata of varied occupations signified mostly by their prestigious status and relatively high education instead of their actual occupational skills. Sometimes the word profession is simply used to describe one's occupation, either to describe the current job and what one does for a living or to separate oneself from an "amateur" (Alvesson, 2004). When someone does a bad job it is said to be "unprofessional" without regards as to whether it was, in fact, something truly professional to begin with or not. Thus the label of being professional is something that most workers strive towards as it indicates both high status and superior skills and knowledge. But it is not in that sense that we use it here. In addition to the previously mentioned definition used by Friedson (1994) we adhere to a number of "*more or less accepted criteria for a real or true profession*" summarized by Alvesson (2004, p.31):

- The occupation is based on a systematic, scientifically based theory.
- There is long and standardized formal education.
- A strong professional association regulates its members.
- Members have autonomy in the sense that professional knowledge rather than bureaucratic position governs decisions and work within the professional sphere.
- A code of ethics is established by the education.
- There is a distinct occupational culture.
- There is client-orientation.
- The occupation is socially sanctioned and authorized.
- There are criteria for certification.
- There is a monopoly on a particular labour market through self-regulation of entry to the occupation.

When discussing the ambivalence of the exact definition Alvesson (2004) points out that if we follow these criteria strictly it is probably only doctors and perhaps dentists, vets and psychologists who would qualify as true professionals. With this he means that the other three classical professions, accountancy, law and clergy, would fail on the first criteria as their disciplines are more based on social rules, norms and tradition rather than true science. However, there are several other occupations that are often referred to as professions and as such it would probably be better to define them according to how high they score on the professional scale. That is: according to how many of these criteria they fit in with (Alvesson, 2004). Irrespective of where we draw the line of demarcation doctors score very high on the profession scale and what is most important to remember in our discussion is that we do not refer to professionals in terms of status, education and skills. These are inherent parts of a profession but are not sufficient for a complete and accurate understanding of the concept, in the way we use it.

4.4.2 The structure of professional bureaucracies

It can be argued that in the light of the diffusion of knowledge and techniques which lead to an intensified competition on the business market the traditional forms of competitiveness such as cost, technology, distribution, manufacturing and production costs have been reduced to table stakes. That, is they are mandatory to have but they are no longer the key to success as they can all be copied or substituted. Instead the only competitive weapon left is organisation (Ulrich, 1997). After a longitudinal research with an international comparison Fölster et al. (2003) asserts that the Swedish health care does not have any resource problems. Instead the existing problems are because of the lack of effective organisation and management. Mintzberg (1993) uses a similar argument when asking what is more important for the effective functioning of our organisations than the structural design.

Mintzberg (1993) argues that the structural design should be adapted to the contingency factors of the situation in which the organisation is operating. One of the contingency factors discussed is

environment, which could be divided into either stable or dynamic and simple or complex. When combined, four different types of environments emerge, as shown in the matrix below. He claims that hospitals are typical examples of organisations operating in complex and stable organisations (also confirmed by Hallin & Siverbo, 2003). During the 1970s and the beginning of the 1980s the previously strong idea of planning was increasingly replaced by the idea of decentralisation in Swedish health care (R. Axelsson, 1998). According to Mintzberg's (1993) matrix this environment usually causes organisations to adopt a decentralized and bureaucratic structure. While the other structures rely on standardization of work processes, mutual adjustment or direct supervision, the decentralized and bureaucratic structure is reliant on standardization of skills.

Standardization of skills means that the work is rather predictable; a patient with a certain problem receives a predefined treatment. But as the art of medicine is very difficult to comprehend it must be decentralized and the doctors are given what can be called professional autonomy. Thus the power and responsibility is put in the hands of highly trained professionals who can understand the very complex but yet routine work (Freidson, 1994; Mintzberg, 1993). They do not have anyone who tells them what to do; they take their own decisions and perform the operational work according to the industry's well-defined, standardized and normative rules, in our case the rules of successful and secure health care.

	Stable	*Dynamic*
Complex	Decentralized Bureaucratic (standardization of skills)	Decentralized Organic (mutual adjustment)
Simple	Centralized Bureacratic (standardization of work processes)	Centralized Organic (direct supervision)

Mintzberg (1993: 144)

Mintzberg (1993) concludes that certain contingency factors are associated with the use of certain design parameters. These situational factors can be grouped into four categories: age & size, technical system, power and the above mentioned environment. He argues that the effective organisation select its design parameters to fit the situation. Hence five structural configurations emerge: the simple structure, the machine bureaucracy, the professional bureaucracy, the divisionalised form and the adhocracy.

4.4.3 The professional bureaucracy

Hospitals are typical examples of professional bureaucracies. The use of the term bureaucratic could be slightly confusing. Freidson (1975) makes a difference between the bureaucratic model and the professional model and says that the "*bureaucratic hierarchy and authority of bureaucratic offices are foreign to the profession*" (p. 9). Mintzberg (1993) agrees with Freidson that the bureaucratic *hierarchy* and *authority* do not exist in the professional bureaucracy; control is exercised in other ways. He refers to the term in the sense that standardization leads to a certain kind of bureaucratisation and writes that it is important to remember that an organisation can be bureaucratic without being centralised. Freidson is, however, aware of this, at that time, rather new concept and mentions, in '*Doctoring Together' (1975),* the "*recent discussion of such 'professional bureaucracy'*" (p.10). He refers to it as a result of the preceding decade's pressure towards strengthening administrative powers through legislation, consolidation and formal organisation of practices. Thus, the previously almost completely independent profession had become increasingly subjected to indirect bureaucratic control while still keeping a lot of the old era's characteristics of an autonomous profession. Four important concepts in the professional bureaucracy are discussed in detail below.

Standardization of skills: When the core work is predetermined and predictable it is, in effect, standardised. However, in highly complex work there can be no vertical specialization where managers supervise the operators' work. Instead the power is disseminated to the operators, in our case the doctors. In order for the professional to both perform and control the work the organisation has to rely on their previously achieved knowledge and skills. The reliance on knowledge and skills, which is achieved through training and indoctrination, is the reason to why the profession requires a standardization of skills. This standardization is what Mintzberg (1993) calls the prime coordinating mechanism of the professional bureaucracy.

Autonomy: When so much power is put in the hands of the professionals they receive an extensive autonomy. It is not the manager who coordinates the actual work; instead this is directed by the professional worker who is dominant in the division of labour (Freidson, 1994). Thus, instead of being coordinated by superiors the doctors are coordinated by the established standards of the profession. There are important benefits inherited in the profession's decentralized power and extensive autonomy. The professionals tend to become highly responsible and motivated with a strong dedication to their work and the clients they serve. This makes this type of organisation unique compared to machine bureaucracies, where a barrier is put between the operator and the client, minimising any personal relationship (Mintzberg, 1993).

The autonomy allows the professionals to perfect their skills without interference and this creates a sense of security for the patient who knows that the doctor has performed a certain kind of surgery so many times that the possibility of mistakes has been minimized. Thus the patient on the surgery table can feel safe, knowing that the professional about to perform the operation will draw on vast quantities of experience and skill, apply these in a perfected procedure, and will be highly motivated in doing their best (Mintzberg, 1993).

Training and indoctrination: Being the key part of the organisation means that the professionals are in control of their own work, and perform their work relatively independently with the clients. This is often done without observation from colleagues and even less observation from management (Freidson, 1994). In professional organisations there is indirect and direct social control. Indirect social control refers to restrictive licensing, formal training and educational requirements. Direct social control exists in the form of self-control: behaviours controlled by virtue of training and dedication from schooling, as well as collegial control exercised in the interaction with other professionals (Freidson, 1975). Mintzberg (1993) refers to training as the process by which job-related skills and knowledge are taught, while indoctrination is the process by which organisational norms are acquired. Indoctrination can often have a negative connotation but in this case it is preferable even if it can have negative aspects if bad organisational norms are adopted.

Part of the indoctrination takes place already during the doctor's education, at the university they are given clues about how a doctor should behave. However, it is not until they start working that the true indoctrination takes place, which socializes the new doctor into certain routines, considering certain ethical aspects and in that way being socialized into a certain kind of organisational culture (Mintzberg, 1993). Conversely, indoctrination also serves as collegial control. If a doctor observes malpractice by another doctor he must intervene. It is common that a new doctor shadows senior doctors for advice for a very long time before they start working more independently. Despite the extensive medical education both on-the-job training and indoctrination takes roughly 5 years, sometimes longer, before the doctor has accumulated a satisfactory amount of knowledge and skills in order to become a skilful and independent doctor. Doctor's usually do not see themselves, or other doctors, as "*finished*" or "*real*" doctors until they are senior doctors (Svenér, 2010: 27).

Professional identity: The professionals' rather protected labour market is according to Freidson (1994) a source of loyalty and identity for the professional membership. The future life career is relatively secured and as it becomes a central life-interest it also becomes a source of personal identification. The doctors are loyal towards their colleagues, the patients and their relatives (L. Axelsson, Edgren & Svensson, 1999). Thus they are loyal to the profession, not the place where they happen to practice it and are more inclined than other employees to leave the organisation if they cannot work on their own terms. The professional requires autonomy and "*when the professional does not get the autonomy he feels he requires, he is tempted to pick up his kit bag of skills and move on*" (Mintzberg, 1993, p.195).

4.5 Organisational Change, Management, and Merger theory

This study adopts an open frame of mind when it comes to the application of theoretical concepts to our results. Because of this, only the main areas of vast spectrum of organisation literature are here reviewed. The specific theoretical concepts with relevance to our findings are, instead, presented in more detail in the Discussion of our findings in chapter 5.

4.5.1 Organisational Change and Management Literature

Some Organisational management, or structural theory, is deemed appropriate to review in this study. This section will deal, in short, with models and theories such as the Value Chain analysis, Lean production systems, Job specialisation and Output control.

Porter's Value Chain analysis (1985) is a model for determining where competitive advantage can be realised. It presumes that the business comprises some type of core business, or core operations, where value is created, and various support functions which should aid the core operations to realise valuable processes. The core business includes inbound and outbound logistics, central operations, marketing & sales and customer (or after sale) service. The support functions include firm infrastructure (such as management, planning, accounting), Human Resources (hiring, training), Technology (such as IT-systems) and procurement.

Lean production system was conceived by Ohno and Shingo, through the Toyota Production System in Japan, and popularized in the west by Womack et al (1990). The general idea of Lean is to seek the perfection of value creating processes through the elimination of waste (e.g. Proudlove, Moxham, Boaden, 2008). The goal is to support the value creating processes, and reduce other efforts. IT-systems in Lean are supposed to assist in the value creation just as any other function (Raman, 1998). Kaizen is one of the pillars of Lean, meaning continual improvement, and Just in time production is another, the central idea being that material and goods should be at the right place at the right time in order to eliminate warehousing and spillage. Other related management systems, that will however not be expanded upon, are Total Quality Management and Six Sigma.

Job specialisation was first revealed as a concept by Adam Smith in his Wealth of Nations (1776, cited in McGuffog & Wadsley, 1999). He stated that the division of labour increases productivity and consequently the unit cost of production, making the business more efficient. Mintzberg (1993) among others expanded on this, and proposes that the reason for this productivity increase is that the employees, through repetition, gain experience which can be used to hasten the process, rationalise the process or improve it with new tasks or tools. Mintzberg (1993) also reflected on the problem with job specialisation; that it requires greater efforts in communication and coordination of the organisation and could also lead to lessened employee satisfaction as they see their field, and areas to influence, decreasing.

Output control can be seen as a rational solution to some problems of management (L. Axelsson, 2000). However, the problem is that in politically led organisations, such as the public health care, some goals are favoured above others that are not too easily measured. Also the premise that goals can be fulfilled through centralised managing and decision-making is also questioned. Kirchhof (1974 in L. Axelsson, 2000) argues that there are three components to output control: formulation of goals, involvement of personnel in decision processes, and that the goals should always be possible to achieve. This is most effectively done with a decentralised division of labour and high degrees of autonomy, with the support of hard and soft data, i.e. both numbers and, for example, employee satisfaction (L. Axelsson, 2000). L. Axelsson (2000) also argues that such control demands good knowledge of work processes, how they relate to each other and what is essential for the outcome.

4.5.2 Merger Theory

Mergers can be categorized into three types: horizontal, vertical and conglomerate mergers. Each type corresponds to a specific need of the merging firms. Horizontal mergers combine two competitive firms with the same set of products and customers. Vertical mergers are when two firms want to get access to the whole distribution chain. Conglomerate mergers occur when two firms want to diversify their business (Malmström & Orre, 2010).

It is pertinent to note that according to studies within the M&A field, few mergers actually succeed in reaching their expected outcomes. Only 30 % of the mergers are successful (Jordan & Stuart, 2000). There are several examples of this from various business areas, with failures rates ranging from 46% (Kitching, 1974 in Cartwright & Schoenberg, 2006) all the way to 77% (Marks, 1988 in Choi, 2011), while Jordan & Stuart (2000) asserts that a mere 30% of mergers are successful. It is also appropriate to note, however, that many of these differences and measurements vary depending on the criteria for success that are used.

In general, Mergers tend to happen for a set of specific reasons, such as creating rapid growth, improving competitive advantage, realizing synergies through increasing financial and operational efficiency such as pure results, reduction of excess capacity and increased negotiating power as well as to optimize conditions for research and education (Bazzoli et al., 2004; Fulop et al., 2002, 2005). Most of the times, it is a complex pattern of motives and no single explanation suffices (Trautwein, 1990). Different classifications abound and models for how the field should be organised. For reasons of convenience, we have chosen to adopt that used by Choi (2011), from whom the structure of this chapter is inspired.

The field of Merger and Acquisitions Theory (M&A) is quite divided, and has been formed from constituents of several disciplines, such as Economics, Finance, Strategic Management and Social Psychology (Choi, 2011). Haspeslagh and Jemison (1991 in Choi, 2011) identify four different categories, or schools of theory. The first, the capital markets school, or the finance school, is mostly focused on the issue of whether mergers increase or decrease value for shareholders of the firms. Hence, the financial performance on an aggregate level, measured as shareholder value, is typically a central theme of this school. Being of lesser consequence in a context of publicly held professional service firms, such as public hospitals, and with more of a quantitative research focus, this school of theory will not be used or developed further in the course of this study. The other main schools of theory are the strategy (or strategic management) school, the organisational behaviour school and the process school. The strategy school is primarily concerned with finding ways of maximizing firm performance and profit and strategies of avoiding obstacles to new value creation. Research also centers on finding the types of mergers that are most likely to be successful and thus the evaluation of the concept of “strategic fit”. The organisational behaviour school rose in an attempt to explain why so many mergers fail to realize expected gains, and has its origins in social psychology, organisational behaviour and human resource management. The school focuses on employee

concerns and resistance to change and tries to explain failure in mergers as a cumulative dysfunctional impact the integration process has on individuals in the organisation, in other words due to a poor organisational or cultural fit. The process school tries to chart the processes of the merger to the outcomes of the merger. Hence, research looks at how management acts to create value in the integration process and what change approach is adopted, such as incremental change. This school also identifies the merger phenomenon as highly context sensitive.
In line with the research question this paper sets out to answer, the organisational behaviour and process schools of M&A theory are the most relevant, and much of the adopted theory will share these origins.

4.5.3 Motivation and Resistance

The organisational behaviour school includes concepts such as employee motivation and resistance. Locke & Latham (2004) argue that a merger may affect the organisational climate and employee motivation. The organisation is dependent on the cognitive work of employees, something that becomes even more apparent during large-scale organisational changes like a merger. The outcome of this is two-fold; it can cause negative effects such as strong resistance and sabotage, but it can also result in positive effects such as renewed confidence, engagement and commitment from employees (Bhal, Bhaskar & Ratnam, 2009). Employee motivation is affected by various internal and external factors, such as the individual desire to work, or the reward in recognition of work well done (Tremblay et.al., 2009). Resistance can take many forms and is a real problem for change managers. It is a common concept that has been charted thoroughly (e.g. Ford, Ford & D'Amelio, 2008, Bringselius, 2008). Most researchers have the conception that resistance is an irrational and dysfunctional reaction caused only by change recipients and must be countered, but some now start to see this differently (Ford et.al., 2008). By assuming that resistance is necessarily bad the change agents may miss the potential contributions of increasing the likelihood of successful implementation through helping building momentum for change and eliminating impractical and counterproductive elements in the design and conduct of the change process (Ford et.al., 2008). Also, using a top down approach to change management, and not listen to those who are experienced in the organisation, under appreciate the need for straight communication and neglect the importance of psychological contracts are ways in which change agents sometimes contribute to the occurrence of the very reactions they label as resistance through their own actions or inactions. This also increases the risk for the emergence of change fatigue and inoculation, as discussed by Palmer et al. (2009) and Ford, Ford & D'Amelio (2008).

4.5.4 Merger and Change Management

Studies have shown that the most effective senior managers recognise their limited power to mandate corporate renewal from the top. Instead they define their roles as creating a climate for change (Beer, Eisenstat & Spector, 1990). Top-down approaches can obstruct the optimal integration between service providers (Kodner & Spreeuwenberg, 2002) as well as obstructing the chain of care development. Chances for successful outcomes are also higher if initiated locally by dedicated professionals (Ahgren, 2007). Weil (2010) also argues for a bottom-up perspective on change management, that practitioners should be engaged early and often, to become more involved in the merger discussions, the implementation and the evaluation, in order to achieve positive results. Alarik (1982) also supports the idea of involving a greater number of people in the plans by asserting that merger results usually get worse if individuals with important business related knowledge are not consulted, especially since organisational-specific knowledge usually is spread in the organisation and not concentrated to one specific group of people.

The speed of mergers has been debated by many researchers. Today there are different views on what is more effective, a big bang approach or a slower, gradual change. The principle of speed has been advocated, for example, by Jordan & Stuart (2000), while others, such as Amis, Slack & Hinings

(2004), argue that large-scale and quick changes might hinder the establishment of trustful relationships and invoke resistance. The problems of cumulative changes are also recognized. The use of a rapid progression of change programs is according to Beer, Eisenstat & Spector (1990) often a result of senior managers wanting to try another change program after previous ones have failed. The problem is that it only exacerbates the problem because they are designed to cover everyone and everything but end up covering nobody and nothing particularly well. It may also lead to change fatigue (Palmer et al., 2009) and, thus, a decreased future change potential.

This concludes the short literary review conducted in relation to our study. In the next chapter, our empirical results will be presented, divided on the different objectives outlined previously.

V – Empirical Analysis and Discussion

5.1 How to measure effectiveness/efficiency

We will here present our findings in response to our first objective with this study: How do doctors and managers believe efficiency is and/or should be measured?

Finding a good measurement of health care effectiveness and quality is an agreed upon dilemma by all participants in our study, though some put more emphasis on the existing problems than others. Top management wants evidence-based data to evaluate changes in relation to improved patient care, work environment, patient security and, not least, improved financials. But they recognize that this is problematic and that there are no perfect ways to capture all the different aspects of hard and soft data. Hard data such as duration of surgical operations, surgery preparation time and numbers of patients received or treated are easy to measure but do not accurately describe how well the patient is doing after the treatment. However, this is not unique to SUS or the Swedish health care system:

> *"In all of Sweden, in all of Europe, people are looking for effective measurements but those real 'super-measurements' have not been found. Instead it varies; they measure some values but do not cover the rest. That is the dilemma with the health care for the moment when it comes to follow-up and such things, to find the correct measurements. We have some colleagues at LUSEM who have spent quite a few years twisting and turning this problem to find solutions, but it is not financial measurements that work." (Top manager)*

Production in health care is measured using the nationally defined DRG values, weighing the resources required to treat each patient. This is also the base for the way health care is financed by the Region and how the hospital is paid for each patient. Hence, top management uses the DRG value of each patient, put in relation to hours worked, to get a working measurement of relative efficiency at the hospital. That is: how much is produced per time unit. For top management this is a simple but very easy way of communicating efficiency, but they also recognize its flaws. They look at how they can develop more sophisticated production measurements and do not in spirit approve with the fact that they are today paid for quantity instead of quality. To measure how many patients have been given a better quality of life would be better than measuring number of surgeries, which does not take into account possible complications or secondary effects that require more treatment. Thus, top managers recognize that every way of measuring has its drawbacks. Nevertheless, they stress that even though the measurement is not perfect, one has to stick to something in order to manage the organisation and be able to do follow-ups. Simply declaring that the existing measurement is unfair will not lead anywhere unless one can come up with a better way of measuring.

Middle management thinks that the production per time measurement is good to have access to, but they would like to relate effectiveness more to production per quality. Quality could be measured as number of complications per surgery, relapses and readmissions of patients and follow-up surgeries. It could also be put into relation to groups of patients, such as the diabetes group, to see how to prevent reduced vision and relate this to the costs of treating that group.

One middle manager thinks that the use of hard data, such as number of surgeries performed, is not that useful considering the complexity of health care. Another one thinks that even though they are not ideal they can be somewhat useful for benchmarking. However, to get reliable results one must standardise as many other variables as possible in recognition of confounding factors. There are many examples of publications done focusing on some kind of measurement, but not all of them are viable, according to the middle manager.

"For example, one study published the best intensive care units (ICU), based on mortality rates 30 days after ICU treatment. They found that Ystad had the best ICU in Sweden. Congratulations Ystad, right? But what type of patients do they have in comparison to other ICUs? You can't compare that." (Middle Manager)

The manager also mentions that, internationally if considering a lot of such different factors, the Swedish public health care is most likely less effective over all.

The doctors' views on how to measure effectiveness is to a large extent the same as the management's. They believe that most of the current measurements are misguiding, and that it should be more related to quality. They recognize that it is complicated and that today, the only viable measurements are the number of patients seen or the number of surgeries conducted, even though they would like it to be more related to quality. Some also think the measurements can be quite unfair since one doctor might treat a few very complicated cases that take a lot of time but is still being measured and compared to someone who has treated several patients with a simpler diagnosis and treatment. Also, it is noted by one doctor that they themselves rate the nature of the diagnosis, so in case of complications some may consciously or unconsciously rate the patient as more difficult, thus giving a biased rating.

What the doctors react most strongly towards is how the management follows the economic incentives established by the financial system instead of prioritizing what medically is the most sound. The financial system has several side effects which in the end forces the doctors to prioritize treatment to patients they do not think should be prioritized.

"There is a big difference depending on whether you admit someone for post-op observation or not. For some surgeries you lose money if you do not admit the patients because you do not get as much money for them." (Doctor)

The most frequently mentioned case is the DRG weighting of cataracts:

"A cataract surgery that you can do in eight minutes today was very complicated ten to fifteen years ago; there we still get a lot of money. But no one says anything since it gives so much money and there are such big volumes that it saves all the rest. So there are areas where it is very askew." (Doctor)

"(…) Cataract is not a dangerous disease, it is just ageing. You will not go blind by not operating it until after three years, really nothing happens, and then we do not have time with the diabetics who get bleedings in the bottom of the eye. Because they are on the waiting list and cannot come in to the doctor who is busy doing cataract surgeries all the time. And they go blind. And the management knows this!" (Doctor)

"(…) it is because we get money if we operate them. And it is a political decision. Cataract is something that that the politicians like. They understand it increases the quality of life to make that kind of surgery one year earlier. But they do not see that there are others that we do not have time to treat." (Doctor)

Dependent on the financial incentives for the hospital, these treatments are prioritized above others, such as the diabetics, sometimes leading to a queue build up that may lead to more severe complications for those patients.

5.1.a How to measure effectiveness/efficiency – Discussion

The problems with measuring efficiency might be a reason to why other problems exist within the health care sector. This is probably because the health care sector is characterized by three different actor groups that have their specific set of norms and values which often result in different desires and conflicts (Hallin & Siverbo, 2003). Measurements are needed in order to perform good management which is crucial for the effectiveness of the organisation. According to L. Axelsson, Kullén Engström & Edgren (2000) the different actors' educational and work background influence how they act. Those close to the day to day operations see themselves as spokesmen for the patients. The senior administrators describe their actions as rational and consider their most important duty to be to implement political decisions. The politicians emphasise current financial conditions rather than current health policy. The differing values will result in different groups wanting to use different measurements as the main or most important measurements. The difficulty in reaching agreement on valid follow-up instruments is an obstacle that has to be overcome in order to achieve increased effectiveness and productivity in the health care organisation (L. Axelsson & Kullén Engström, 2000). The problems that the doctors mention in our study can be attributed to the balancing between emphasising either economic efficiency or medical effectiveness.

When an organisation is subject to pressures with incompatible signals it might lead to contradictory messages being sent to the organisation and insufficient correspondence between idea and practice. When there is no correspondence between what is said and what is done the result is hypocrisy which in time leads to an increasingly expressed despise for those who take the decisions. This is a situation that easily emerges in complex professional organisations such as health care, especially when governed by politicians (Elmqvist, 2002; L. Axelsson, Kullén Engström & Edgren, 2000). The governmental investigation leading to the legislation on priorities within health care is based on ethical principles which put the principle of need above the principle of cost efficiency (SOU, 1995:5). This ethical order of precedence is in correspondence with the professional ethics of doctors discussed in the theoretical chapter of professional bureaucracies. The prioritizing of cataract surgeries over for example diabetic patients in our study shows an example of how the ethical considerations established by law and profession clashes with the economical considerations established by politicians and exercised by the management. When economic incentives override the doctors' medical expertise in terms of which patients' needs should be prioritized the doctors become frustrated. In the end it might lead to increasing mistrust between doctors and management/politicians as disagreements grow regarding how health care is governed. Florence Nightingale apparently phrased the problem quite simply in relation to quality management:

> *"The ultimate goal is to manage quality. But you cannot manage it until you have a way to measure it, and you cannot measure it until you can monitor it."*
> *(Nightingale, in Arah et al., 2003: 377)*

We can confirm that the same sentiment goes for efficiency in our study of the SUS merger.

5.2 Purpose of the merger

When doing a major organisational change, or any kind of change for that matter, the purpose is most likely to improve something. It could be to improve the input, output, effectiveness or efficiency etc. To identify the purpose behind a costly and cumbersome transformation is a way to identify what is valued and what is seen as effective enough to make that change happen. The purpose of the SUS hospital merger has been much debated and in our study we have found several different ideas of what the purpose might or might not have been, or if there was any at all.

5.2.1 The official purpose – economic or not

According to the Proluma web page (skane.se/proluma) the objectives of the merger were to attract, concentrate and develop competence, which in turn would lead to a better business, care quality and research. It was also to strengthen economic capacity through realizing synergies, increase efficiency and improve the productivity. The SUS merger had the purpose to utilize the collected resources in order to achieve increased national and international competitiveness. The secondary objectives were to increase competence and improve the clinical research and business through establishing a high enough critical mass of patients (Region Skåne, 2010b). In the two processes it is thus possible to identify a slight difference between the wordings of the two purposes.

Much of the debate surrounding the merger has been about whether the purpose of the merger was of en economic character or not. According to the top management the purpose was not economical and they are emphasizing this strongly. Instead it is to increase the competitiveness locally, nationally and globally. It is a competition about making the inhabitants stay for treatment in Skåne or to attract patients from other regions or countries. It is also a competition of being selected for major assignments such as national health care (Rikssjukvård), where there are only two hospitals in Sweden who deal with a certain kind of highly specialized health care, or the placing of large institutions such as the European Institute for Communicable Disease Control, which is mentioned as a failure where Stockholm easily won the assignment due to competition between Lund and Malmö. But what is most frequently mentioned and emphasized is the competitive power of research and competitive ability to receive research funding.

Among the doctors the perceived purposes are not in accordance and three categories can be identified. First, some doctors say that the official purpose was some kind of increase of competence, competitiveness or synergies, either one of them or a combination, and that they had been told that there were no financial purposes. Among these doctors there were those who either bluntly said that they did not believe it was so, they believed there were financial reasons for the merger, and there were those who said that they hoped the official purposes were true and that it was not the economical purposes that governed the merger. None of these doctors believed the top management's reasons entirely. Second, there were some doctors who said that reasons were entirely economical and accepted this as perfectly normal. They showed no signs of knowing that the management have been denying this, nor any signs of valuing the legitimacy of this purpose in any way other than saying that they failed to accomplish this. Third, there were those who said that the purposes had changed over time.

> *[Interviewer: What was the purpose with the merger?] "Well, that is interesting because back then it was said that it was because of economical reasons, what was stated during the presentation. When this was questioned, it was apparently no longer so, instead there was the competitive power that would be strengthened, outwards. If it was against Copenhagen or Stockholm or Göteborg who were a threat, I do not know. But it shifted; if you questioned one or the other reason, then it was changed. And that gave us a very strange picture of why it was like this. It started a lot of talk and intrigues. (…) It was*

presented as purely economic; the division manager even showed how the costs were increasing on the blackboard." (Doctor)

The middle management simply asserts that everyone thinks that there were economic reasons behind but that the top management stated that this was not the case. Despite not having economical reasons as a purpose for the merger the top management does affirm that they hope and believe there will be positive economic benefits following the merger. It is also said that cost efficiency is included in care quality and that is the basis for maintaining a competitive power.

"The entire Proluma process, and also the fusion process, has until today not had any demands for any economic conditions. But since we are in a position where we have a four-five hundred million deficit we realize we have to bring home the rationalizing effects that we can create." (Top manager)

5.2.2 Legitimacy issues

The legitimacy issues that emerged have partly been mentioned. A strange picture of what the actual purpose was resulted in a lot of talk and intrigues. The purpose was perceived as shifting when questioned and the purpose was never fully explained satisfactory, even though the change to a large extent involved the possible destruction of existing and well functioning structures. Some doctors became suspicious of who the persons involved where and who was actually behind the decisions. When it comes to the placement of the eye clinic there was a lot of talk about whether the clinic had become an article of exchange in a bargain. In December 2007 a study suggested that the eye clinic in Malmö should be moved to Lund and there was an agreement on this (Region Skåne, 2008h), but in the beginning of 2008 the decision was the opposite. Equal numbers of units should be moved to and from each of the two hospitals. Some doctors perceive the placement of the eye clinic in Malmö to have been a bargain either to make the number of units moved between the hospitals equal for them to maintain the prestige or that an influential division manager traded the eye clinic for the jaw surgery. Supposedly it was decided that the jaw surgery was to be moved from Lund to Malmö but that this was reversed for some unknown reason. The doctors mentioning this emphasise that they do not know whether this is true or not but it was a general conception shared by several doctors. One doctor describes how the management explained that the changes could not be optimal for all the clinics within the same division, as they were among the first ones to start this process. They were aware of the fact that it would be uncomfortable but it was necessary and the eye clinic would have to bear with this, for purposes of fairness. For the doctors this was very hard to understand since the eye clinic in Lund was so much bigger, and logically would be the clinic that could most easily accommodate the other clinic's operations without major restructuring and disturbances.

5.2.3 Identified advantages and disadvantages

We have identified more specific reasons in addition to the official and most often mentioned purposes such as a concentration of competence, increased competitive power and quality as well as the much debated economic reasons. These could be both theoretical advantages, what ought to be good when merging two hospitals or two clinics, or what the actual sought after advantages in this particular merger was.

In the governing document for the entire change program it is declared that the selected units will be merged with one management placed at one of the sites and that inpatient care and emergency care is to be focused to one of the sites, while a smaller part of the business can be located at the other site if special requirements can be indicated (Region Skåne, 2008c). These are some specific objectives that are also mentioned by the top management. The establishing of a more attractive

workplace, better coordination between the two hospitals as well as with the university and medicine faculty, and an achievement of a larger pool of patients in order to create a critical mass are also advantages mentioned. It is argued that concentrated competence can increase the chances of innovation and that expensive equipment, surgery rooms and administration can be better utilized in order to save money. It is also argued that the organisation is decentralised through the establishment of one line of managers, each being responsible for a hospital, division or clinic. It is said that this is to achieve decentralisation through centralisation in the sense that the clinical manager can make decisions regarding both of the geographically separated sites since they are managed as one clinic. In the same way the division and hospital management is unified into one, but with two geographical placements. To a large extent the middle managers mention the same advantages. The disadvantage mentioned by the management is primarily the geographical closeness to the patient, which is reduced.

Aspects that are considered both an advantage and disadvantage is the competition between the two eye clinics. Both management and doctors recognize that there can be advantages with a healthy competition where one clinic spurs the other, as well as disadvantages where the competition can become destructive. However, some of the doctors and a middle manager indicate that some of this destructive rivalry was created by the actual merger process and that the rivalry that existed before the merger was not of a problematic magnitude. Another advantage mentioned by a middle manager, concerned with the non-acknowledgement of the size and complexity of eye health care, is that a bigger clinic might receive more importance, attention and thus influence. On the other hand a smaller organisation does not require the same amount of managers and is much easier to manage compared to a large one. Having the clinics and divisions at two geographically separated locations is also mentioned as a disadvantage by both the middle managers and doctors.

The doctors think that the theoretical advantages could be a concentrated emergency duty, administration and the highly specialised competence, as well as avoiding sub-optimisation of specialities. The disadvantages they mention are that the clinic becomes too big and people do not know each other as well as before which impedes informal communication. They also think that this makes the managers more controlling, meddling with doctors' affairs by making more detailed decisions regarding how the doctors should carry out their work. A doctor says that "*of course you do not dare to delegate as much as if you knew everyone*". Yet a disadvantage mentioned by the doctors is that they can no longer change employer. If someone was unhappy or had a conflict with colleagues at one of the clinics he or she used to be able to change employer and work at the other clinic, without having to move further away. This is a reason to why some of the rivalry emerged between the two clinics. The merger forced these individuals to start working with each other again as well as arguing for why one or the other clinic should be moved, which caused a lot of destructive conflict. Out of a salary perspective it was also an advantage with two clinics since it was possible to change employer and thus renegotiate the salary. One doctor thinks this might have been one of the reasons why top management wanted to merge, too keep down salary escalation. In the end, three years after the merger the doctors are still unsure about the purpose and objectives of the merger.

5.2.a Purpose of the merger – Discussion

According to R. Axelsson (1998) it can be difficult to establish concrete and clear objectives in complex professional organisations. Within health care these are often unclear and controversial. There are common "parade goals" such as "health to everyone" that are so generally formulated that they hardly are of any value or guidance within the practical health care business. Beer, Eisenstat & Spector (1990) write that buzzwords become a substitute for a detailed understanding of the business. We would comment that the arguments of competitive power and competence concentration used by management might have become such parade purposes from the doctors' point of view. The doctors did not feel like they received a convincing explanation of how these goals

would be achieved, instead they believed the merger would have the opposite outcome. Posnett, (2002) argues that the burden of proof must be with those who propose a concentration to quantify the expected benefits and costs and to explain these to the doctors. Furthermore he argues that the process by which benefits will be realized in practice must be equally explained as well.

In our study the doctors and management shared several ideas of the theoretical advantages but the top management thought there were several more advantages that the other groups did not mention. The doctors and middle management on the other hand were to a larger extent taking the disadvantages into their considerations. According to Alarik (1982) this is not uncommon as advantages are usually exaggerated and favourable information is emphasised by management, while the corresponding problems are underestimated and neglected. When there are possible negative consequences identified by the management it is important that they are open with these. Ford, Ford & D'Amelio (2008) describe how communicating a representative view of the merger is important. If the chances of success or failure are not truthfully explained this might result in resistance from the employees. Hence, realistic previews help the employees with getting through a merger process when it comes to coping with uncertainty and adapt better to the possibility of dysfunctional outcomes (Schweiger & DeNisi, 1991).

Alarik (1982) describes how personal relationships are very important in a merger and that emotional factors affect the merger which is based more on mutual trust than on formal assessments of the opportunities. The doctors describe how they perceive their clinic to have been a bargain between influential managers where one did not want "his" jaw surgery to be transferred from Lund to Malmö. Presumably this was based on emotional factors and mutual trust between the influential managers instead, which led to the revocation of a decision that the doctors perceived as taken. Whether this is true or not is sadly not of great importance, the mere existence of this perception among the doctors can be detrimental for establishing trust in a change process. By failing to legitimize the change the change agent can in fact contribute to the occurrence of resistance (Ford, Ford & D'Amelio, 2008) due to the failure of establishing trustful relationships, which in the end might have a negative effect on the merger (Amis, Slack & Hinings, 2000).

In conclusion, despite the fact that management and the doctors to a large extent agree on several of the theoretical advantages, it is mostly middle management and doctors who also consider the disadvantages of a merger. In order to avoid negative results it is the responsibility of those who advocate mergers to prove their case regarding the benefits of the envisaged merger (Canadian Health Services Research Foundation, 2004).

We will now discuss the results of the merger and how its outcomes are perceived differently by the three different study groups. While the top management is positive about the results the doctors believe the envisaged disadvantages were fulfilled and the possible advantages unrealized.

5.3 Perceived results of the merger

Due to the vertical diversity of our study the perceived results of the merger are influenced by the organisational positions of the participants. The top managers evaluate the merger more out of a perspective encompassing the entire hospital while doctors evaluate the merger from the perspective of their operational specialty. In between the merger is evaluated from a divisional or clinical perspective etc. The pattern is clear: the further up the individual is in the hierarchy the more positive he or she is while further down the organisation negative perceptions of the results are the most prevailing.

The management believes that the merger has been successful. They mainly mention the improved possibility to coordinate between the two different hospitals as well as good results on a hospital level in terms of increased productivity, quality, budget surplus, cost control and other reforms. We asked whether the original goals with the merger were achieved:

> *"Yes, we have delivered. And that is also the reason why I am here to begin with."*
> *(Region Director)*

The reason as to why the merger continued from Proluma (merging fourteen initial clinics) to Proluma II, which was converted to the actual SUS merger where the entire hospitals were merged, was that the results were so good. Regarding the existence of negative results the top managers admit that the final results were good, albeit not without some problems. The main problem that still remains is the problem with coordinating the IT systems, which the top management attributes to the cultural differences that existed between the hospitals, where the hospitals had different routines and used different medical terms.

The top managers say that there were no long-term negative consequences and that they do not know if any of the initial problems still remain. They assert that there were several clinics that "*initially were a little problematic*" but that these problems were corrected rather quickly. They also agree that there was some loss of competence but that they are about to re-hire new personnel and that, as mentioned above, the effects of the competence loss are not lasting.

The middle managers are not as positive to the outcome. One is hesitantly positive and says that the merger probably was correct but that it depends on where you look. Some clinics have managed well but others have had very severe negative consequences. Another one mentions mainly negative consequences. One of them says that so far the patients have not been affected negatively but on the other hand it is still admitted that the severe competence loss is negative for the patients in the long run as they might not get access to the competence they might require. There have been cases where the fusion directly affects patients negatively; often in such a way that they have to travel to Stockholm or Örebro to receive treatment that they can no longer receive in either Lund or Malmö, and that this brings about risks of deteriorating health status (Skånska Dagbladet, 2011).

Among the doctors the negative perceptions on the results are overwhelming. All the doctors said that the objectives have not been achieved at all, rather the opposite. Some of them mention that it might become better for resident doctors who are still learning since they can visit both the clinics and see a broader spectrum of patients; but this is also the only positive consequence that we have been able to identify. Many of the doctors bluntly answered "*no*" to the question whether there were any positive outcomes. As discussed above most of the doctors agree on the theoretical advantages that might occur, but they do not believe that these have been realized. Instead they argue that the result is the opposite of what was envisaged with a loss of competence as well as worsened organisation, economy and competitive power. Below we will discuss these different consequences separately.

5.3.1 Competence loss

The competence loss is the most frequently mentioned negative consequence by all the interview participants. But it is not seen as something that has severely damaged the operational work at the clinics. The top managers mean that the lost competence has been partly replaced by new recruits.

> *"No, it has not had any lasting consequences. We have lost doctors, we have lost personnel. But on the units where we lost personnel we are about to re-hire. (...). We have mainly lost doctors but even other personnel. It is also so that some have realized that it was not greener on the other side and have come back." (Top Manager)*
>
> *"So it is the same doctors that left who are coming back?" (Interviewer)*
>
> *"Nah, not really, not by a long shot. But there are those who probably thought that it was greener in other places and later realize that interesting things are happening here and that maybe they should participate in that." (Top Manager)*

When asking a doctor we were told that those who left had not returned and that the newly recruited doctors certainly were good and competent doctors but did not have the 10-30 years of specialized experience as those who left. And in numbers they were not close to fill up all the empty positions. The managers explain the competence losses as mainly due to the rivalry between the clinics:

> *"There were some key persons within eye surgery, for example, that in indignation or despair over our decision... well... if you want to banter a little: there were some who absolutely would not consider to, if you live in Lund, go to Malmö and work, and not cooperate with the corresponding clinic either." (Top Manager)*
>
> *"There has been some kind of antagonism between them where one has looked down upon the university part in Malmö as well. Lund University is just as big in Malmö as in Lund when it comes to the hospital point of view. That aspect was a little frightening I think, it also led to, in some areas, a competence loss, mainly within the eye surgery." (Top Manager)*

According to the top managers the competence loss is not necessarily negative either:

> *"We do not have the full picture [of how many have left]. We have not said that it is what is important. Instead the important thing is the results that we achieve through these changes that we are doing. Then you know that in all of these changes there is bound to be some turbulence. And some do not like that. And sometimes it is actually good that those who do not like this do not stay, from the perspective of the operational core, because they have another attitude and are probably a better fit for another organisation. And others should come to us instead because it suits them better. So you must have some respect for this, everyone cannot be equal and everyone cannot participate." (Top Manager)*

The middle management thinks that the competence losses are more severe and say that it is a critical issue when competent colleagues who maintain the operational core business are lost. Especially since this forces the clinic to pass on patients for whom the clinic is supposed to be "*the final destination*" of referral.

The doctors consider the competence loss very damaging for the clinic. One doctor describes how they used to be 33 doctors in Lund and 23 or 24 in Malmö, almost as many as 60 in total, and that

they now are 40 in total. They say that 18 doctors have left or are about to leave, since we were told that two were leaving during our study. Moreover, after the Proluma process and before the SUS merger, there used to be four retina surgeons in Malmö and one in Lund but the two who are leaving are both senior doctors from Malmö. There are now, ex-post, two junior and one senior doctors remaining, one doctor says. But the remaining senior doctor is placed in Lund while the two junior doctors are placed in Malmö. There used to be four seniors in Lund and two seniors plus one junior in Malmö prior to Proluma. (Note: what we refer to here as a junior doctor is what our interviewees refer to as a doctor who is not entirely independent. Considering the highly specialized care these surgeons need approximately 10 years of experience before being considered independent, according to one interviewee.) After Proluma and the numerous voluntary resignations one of the most experienced doctors with over 30 years of experience, referred to as "*one of the top three in the country*", was recruited. But during our study we were told that he resigned in frustration during what is referred to as the aftermath of the merger and its residual problems.

A middle manager says that while the junior doctors might consider it a challenge to be part of this kind of process, the senior and most competent doctors may not feel like they want to "*sacrifice [their] last years on this*". The doctors think that this is extra critical to the future of the eye clinic since newly recruited doctors cannot profit from their unique and exclusive knowledge and competence. They describe how a doctor with 20 years of experience still has a lot to learn from those with 30 years of experience. Thus the knowledge transfer will, according to the doctors, have long-term effects that are not going to be replaced until after 10-20 years when the existing doctors have accumulated the corresponding experience. Especially since the doctors are so highly specialized and there might be only one to five doctors within some specialities.

Some of the doctors who left did not do this directly because of the merger. But when so many doctors left there were a lot of senior doctor positions available that were filled by junior doctors. This is the only time when you can raise your salary except the annually fixed salary increases. The quick depletion caused the salary escalation among doctors much younger than the other senior doctors. Suddenly the younger doctors earned 10 000 to 20 000 SEK more per month than the older seniors who still continually taught them, helped them and transferred their knowledge down. Thus some of the older seniors got frustrated and felt like they were treated unfairly and left.

The competence loss was also in terms of nurses. The established inpatient ward in Lund had nurses with several years of specialized experience. When moving the inpatient care to Malmö these were not brought and instead the new ward unit is shared with plastic surgery, the otorhinology (ears, nose and throat) clinic and the breast cancer clinic. In Malmö there is now only one nurse with eye care experience, the others do not have specialized eye education or experience and can thus not do the same kind of effective work, instead having to transfer more of the work back up to the doctors.

The same problem exists with on-call duty. Some queries used to be taken care of by nurses directly, but now most calls are transferred to the on-call doctors immediately. During the night the on-call duty doctors used to be woken up once every fourth nights but now they are woken up four to five times each night since there are no longer any nurses who can take care of these inquiries. One doctor also mentions the loss of secretaries due to management's idea to reduce the secretaries from "*if it was from 1.8 to 1.6 secretaries per doctor, I do not remember, but it was something like that*" and that this resulted in an increased work load for the remaining secretaries. As a consequence, some quit due to the worsened work climate, which further increased the work-load of remaining secretaries as well as doctors in a kind of vicious circle.

5.3.2 Organisation

The organisational results mentioned by the top management referred mostly to successfully organising the hospital governing functions and the divisional structure. They also mention their idea of dealing with the initial cultural problems. They did not aim to unite the two cultures but instead to create a new one and they say that they were successful in doing this.

The middle management makes comparisons to other clinics and say that those that were successfully concentrated to one area have achieved good results but there are several examples where this has not happened and those clinics have had problems as well, the most severe of which is the eye clinic. Middle management describes the current work as repairing and "*trying to save the operational core business*". The problem is that the operational work has been divided geographically, the capacity has been reduced and the organisational fit and structure has been destroyed.

The doctors describe the same things and bring up several different issues. In Lund they used to have 12-16 inpatient ward beds with specialized eye nurses while in Malmö they had 4 beds that were shared with plastic surgery and hand surgery. The reason to why Lund had so many more beds was that they had the largest retinal surgery which has a higher demand for inpatient beds. The idea of the top management was to reduce the inpatient beds and concentrate them to Malmö. They said that the eye clinic in Malmö would have five guaranteed beds (also mentioned in a document: Region Skåne, 2008d) but when they noticed this was not enough it was extended to eight, shared with plastic surgery, the otorhinology clinic and the breast cancer clinic. However, they noticed that this was not enough so they are now sharing four beds with ear surgery in Lund as well. In total they have fewer beds that are now shared with other specialities where the nurses have no knowledge of eye care and they are spread on more geographically separated locations in a "*confusing*" and "*weird*" manner. When closing down the existing inpatient ward unit in Lund in Malmö it was not simply spread on different locations in Malmö but it also forced the existing structure in the Malmö clinic to be broken up and spread around in order to accommodate the Lund operations. In the shared ward units the fit between eye care and the other specialities is also not optimal. The eye care patients come and go much more frequently since they only have to stay a day or two while the other patients stay for several days. The turnover of eye patients is higher which disturbs the routines of the other specialties. Overall the capacity has been greatly reduced, says a doctor.

The result is that patients sometimes have been sent in taxi between the two hospitals or been referred back and forth to get some treatment at each site. The same goes for surgery. Instead of being spread on two surgery rooms they are now spread on three that are shared with other clinics. The reason to this was simply that there was not enough space in Malmö when moving there.

The on call duty was also merged. From having two on-call duties, one in each city, these are now reduced to one. The combination of having twice as many patients but reduced number of educated nurses has negative effects on maintaining an effective on-call duty. Previously the nurses could take care of night time issues but now they have to call and wake up the doctors much more often as explained above. This will also be commented upon in the following chapter on efficiencies.

Other issues such as communication and relational aspects have suffered negative consequences according to the doctors. Instead of having the eye clinic manager close at hand at all times he now has to travel between the two sites since they are merged into one clinic with one management. Existing informal relationship such as who to talk to and rely on has been broken. The same goes for inter-specialty networks where the eye clinic cooperated with other clinics on multi-trauma patients.

In total the number of visits with a doctor or nurses has been reduced from 90 000 a year to 50 000 a year according to a middle manager. In addition to the loss of visits due to the competence loss of

doctors and nurses this is also, according to a doctor, explained by the need for doctors to travel between Malmö and Lund for weekly meetings. After the merger the doctors have to go to Malmö or Lund every second week which requires half a day instead of an hour at the end of the day. The doctor says that the hourly loss each week corresponds to 5 000 patient consultations each year.

In the future the doctors, from both the Malmö and Lund site, believe that the management will realise that it is not sustainable the way it is organised now. They say that the clinic is completely drained and ruined; they will have to build a new common building. If this is done then eventually the clinic might build up sufficient competence and hire enough doctors, nurses and secretaries, create a good education situation and connections to research. "*But I do not think it will exist much earlier than in ten years from now*." Others are not so optimistic but say ten to twenty years. However, we also note that at the moment of writing, there are plans to demolish all eye clinic buildings and centralise to one location, starting as early as next year (Skånska dagbladet, 2011b). This could satisfy some of the problems.

5.3.3 Economy

The merger did not, officially, have any financial purpose; at least not as it was later revised after the first Proluma announcement. On the other hand the competitive power was envisaged as the main objective; the competition for patients and thus income. Other regions voiced concern about the outcome of the initial Proluma merger and what the results would be since they wanted to know if it would remain safe for the patients to keep sending them to Lund or not (Region Skåne, 2008b) and the previous Lund clinical manager argued that the temporary effectiveness decrease would make the other regions negotiate agreements to send their patients to other clinics in Sweden or Denmark which would have permanent effects (Region Skåne, 2008a). In the end the result is that the eye clinic sometimes has to pass on patients to other regions even though the eye clinic in either Lund or Malmö used to be the final destination for these cases. There are cases where the patients have been exposed to big risks due to this (Skånska Dagbladet, 2011a).

> *"Before the merger Lund had patients coming from almost all clinics in the south of Sweden, retinal and corneal cases. Almost all of these disappeared after the merger. Patients are being referred to other Swedish clinics instead. This is due to our lack of surgeons and beds. One argument for the merger was that the joint clinic was going to be more competitive in comparison to the Copenhagen clinics and other big clinics in Sweden. This has not been the case. On the contrary we are now less competitive." (Doctor)*

Other regions, such as Halland, Gotland, and Kronoberg, are no longer sending some of their eye patients to Lund because they have no confidence in what remains of the eye health care. There is a lot of income from other regions in this health care that is lost. There is also a lot of money lost in sending the patients between the two different hospitals due to lack of capacity and ability to do some specialized treatments at one of the hospitals. Mostly the patient's have to pay the travel by themselves, but sometimes the hospital has to pay transportation service or even taxis, which is something that several of the doctors mention. When the doctors have to travel between the hospitals this is of course something that the hospital has to pay for as well. According to a doctor the actual physical move between the two hospitals was also very expensive, especially since the lack of planning called for several temporary solutions that later had to be re-adjusted.

Further costs are increased due to worsened treatment as well as the impaired possibility to diagnose and treat the patients completely during one visit. More unnecessary patient visits mean higher costs according to the doctors. There is also the on-call duty. We have described how the doctors are contacted and woken up much more often. When this happens they receive twice the

normal pay, or two times the on-call compensatory leave, instead of the low on call duty wage. Not to mention that the doctor's salary is much higher than a nurse's to begin with and that the previous nurses could cover these inquiries during their regular night working hours. Thus, as one doctor describes it, they have saved money by closing the on call duty in Lund but on the other hand those who are now working in Malmö has twice as much to do and they receive higher compensation.

> *"I do not think that they save that much money on it. But they are probably imagining themselves that they do." (Doctor)*

A possibility for this is that the difference is lost in the accounts, meaning the on-call compensation to doctors is paid out of another account than the salaries of previous night shift nurses, concealing the imbalance.

5.3.a Perceived results of the merger – Discussion

In merger theory there is strong empirical evidence of mergers having the negative impact that scholars have suggested (Schweiger & DeNisi, 1991). But considering the increased pace of recent organisational changes in health care there is surprisingly little attention being paid to organisational research (Aiken et al, 1997 in Aiken & Sloane, 2002). In many instances organisational reengineering has led to worsened cost competitiveness for hospitals, compared to other hospitals in their vicinity (Walston, Burns, & Kimberly, 2000) which often can be explained by opposition, especially from health care professionals who work independently and autonomously (Redfern & Christian, 2003). Little is known about how many of the organisational changes actually affect the patient and the outcome of treatments (Marmor, 1998; Leatt et al., 1997 in Aiken & Sloane, 2002). Much more information is required to understand the processes that drive good outcome. On-going training, teamwork, adherence to evidence-based protocols and appropriate support services are important factors that should not be overlooked (Posnett, 2002).

In general, different interventions seem to be blunt tools to achieve change. Especially organisational interventions seem to be as likely to prevent access to efficient interventions as to efficient ones (Freemantle, 2002). Considering the need for change that exist in many organisations (see Palmer, Dunford & Akin, 2009) our interpretation of this is that either the wrong hospital organisational changes are effected, or they are carried out in inappropriate ways. Aiken & Sloane (2002) seem to share this belief claiming that organisation and culture are factors that are not appreciated enough in explaining hospital outcomes. They continue by arguing that a better understanding of how clinical care is influenced by these factors is key to preserving hospitals' favourable influence on patient outcomes as well as reducing unnecessary costs where this is actually needed.

In studied countries, such as Canada, Denmark, Sweden, the United States and the United Kingdom, the negative consequences following hospital reorganisation has been professional and public discontent where unsafe professional staffing levels and eroding quality of care have been cited (Aiken & Sloane, 2002).

In our study there are no statements of patient outcomes being directly affected negatively. However, the total production has been greatly reduced which decreases the patient's access to appointments and treatments; competence loss impairs the access to the most qualified doctor; and as discussed above, in '*How to measure effectiveness,*' there are patient groups who are not receiving their treatment in time due to the financial system. However, these factors are more in relation to capacity, ability and prioritizing and not specifically organising.

But there is some research relating patient outcomes to organisation or the effects of organisational changes. After studying an abundance of research Aiken & Sloane (2002) conclude that there are

indications that nurse staffing and skill mix are important determinants of patient outcomes. Their own research showed that independently of the individual skills and number of nurses there are also signs of patient outcomes being affected by how the nursing care is organised. They found that dissatisfaction and burnout among nurses is directly correlated to patient dissatisfaction and quality of care. Pearson et al. (2006) have also found that greater proportions of regulated staff and registered nurse hours are associated with improved patient outcomes and that this should be kept in mind when determining the level of staffing and workload which is directly related to voluntary resignations and emerging nurse shortages (Davidson et al., 1997).

When relating this to the SUS merger we see that spreading the ward units on different locations, replacing specialized nurses with nurses who are also serving other specialties with different routines, and increasing their workload, might have negative effects on the patient outcomes. This has been observed in some processes where care has been disrupted, dissatisfaction increased and turn-over of personnel increases, which leads to personnel shortages.

One of the arguments for the merger was to increase the quality of the care. According to Posnett (2002) the determinants of patient outcome are poorly understood and the emphasis on volume as an alternative for the skill and experience of individual doctors on clinical level is likely to be misplaced. Consequently, in the SUS merger it might be hard to justify losing some of the most experienced doctors in Sweden within their fields. Affording to lose 18 out of almost 60 doctors, some of which are among the only 25-30 specialists in Sweden, might not be compensated with the synergies envisaged from merging two clinics, especially not when these remain at two different sites. Posnett (2002) continues with arguing that the optimal scale of an emergency care hospital is dependent on networks and interpersonal relationships between specialties within the hospital. According to the eye clinic doctors these have partly been broken or threatened.

The effects of losing personnel are discussed in turnover research. There are several negative aspects of personnel turnover such as selection and recruitment costs, training and development costs, operational disruption and demoralization of membership (Staw, 1980). Turnover is, however, twofold, and the conventional assumption that low turnover is preferred is not always true (Glebbeek & Bax, 2004). Instead it should be seen as a contingent phenomenon where the organisational conditions determine whether employee turnover is beneficial or not (Ton & Huckman, 2008).

Considering the amount of skills, experience and specialization needed within professions in the form of on-the-job training and indoctrination (Mintzberg, 1993) and the testimonies of our interviewees we cannot identify that any of the positive consequences from turnover mentioned by for example Staw (1980) are generally contingent to hospitals and the doctor profession. At the same time it is a plausible assumption that hospitals and the doctor profession generally are characterized by a low employee turnover; at least this was the case in our study of the eye clinic where several doctors have spent practically their entire careers at the same work place. Settings that require high levels of knowledge, which is certainly true in the case hospital personnel and specialist doctors in particular, are generally affected negatively by high employee turnover. Ton & Huckman (2008) confirmed that firms with a low turnover suffer larger negative effects on performance from the loss of an employee since this employee leaves with substantial experience. The corresponding effect is also true where firms with high turnover do not have the same negative impact on performance due to lower levels of accumulated experience being lost.

Eventually the competence loss affects the competitiveness and consequently the economy in other ways than the negative aspects mentioned by Staw (1980). The loss of patients due to interregional health care competition is a cost over which the domestic region has very limited control (Hallin &

Siverbo, 2003). This is clear in the case of the eye clinic merger where other regions no longer dare to send their patient's to Lund but send them elsewhere instead.

The discussion above is a reflection on how the doctors and management perceive the results of the merger. According to them this might be just another example of the failed hospital fusions described in merger literature (Jordan & Stuart, 2000; Weil, 2010). A final remark on the result of the Proluma and SUS merger is that one of the most important reasons to why the expected advantages of size do not appear in horizontal mergers can be derived to imperfections in the fundamental business idea (Alarik, 1982). We will now continue by discussing the process of the merger and how management and doctors perceive the events that led to their respective perceptions of the results described here.

5.4 The managing of the merger process

We have discussed the envisaged purpose, objectives and perceived advantages and disadvantages. Furthermore, we have discussed the existing differences in how the results of the merger are perceived by the different actors. We will now discuss how this gap might have emerged by describing how the merger was managed and how the doctors responded to this; because the way in which a transformation is managed seems to be a key to successful organisational change.

> *"In a national sample of hospitals, reengineering alone was not found to improve the relative cost-competitive position. Organizations attempting to improve their cost competitiveness must consider the way in which change is implemented." (Walston, Burns & Kimberly, 2000)*

To this end, we will here discuss the managerial perspectives on the use of theories, management's apparent focus on the top of the organisation, operational staff's voice and opportunity to contribute to the process, possible explanations to the problems encountered and the view that the approach to change was perceived as unrealistic and contradictory.

5.4.1 Managerial perspectives on the use of theories

We asked the top managers whether they had used any experience or inspiration from other major hospital mergers or theories and theoretical frameworks. We also asked the doctors and middle managers if they had noticed the use of such elements by the top managers. One top manager mentions several different business development theories that he has seen during his years as a manager, including Total Production Systems, TQM, Six Sigma et cetera. The manager claims to "*have seen all of these letter combinations*" (Top Manager). Other literature mentioned by the same manager is about intellectual capital, leadership and Lean. Overall the top management shows a lack of confidence in the practical usefulness of theoretical literature. One mentions that he has a kind of "*allergic reaction*" to them because they are too theoretical and they come and go with the same "*prophets*" proclaiming the necessity of this new "*letter combination*". Instead, they would describe themselves as rather pragmatic. They have "*followed the development in the surrounding world*" and at least tried to learn from what was done in Stockholm and Göteborg, where one of the managers says there were several problems. But all the top managers claim that it is mostly their own vast experience, gained during their careers, that has been used.

During the discussions following the announcement of Proluma the doctors said that there will be competence losses. According to one of the doctors a top manager's response to this was: "*that is what everyone always says and it is just empty talk*" (Top Manager). Basically there is only one change management conception used by the absolute top management of the merger. Regarding if there was any use of theories the initiator of the merger process answered:

> *"Well, not really from my side. Except the general principle that it should be done relatively quickly. It should be rather clear and simple information when carrying through such huge changes. The more academic you make the information the more painful it becomes in a way." (Region Director)*

He is aware of the existence of theories and research that propose that classical merger strategies are unsuccessful and that an incremental, emergent, bottom-up approach seems to be a better merger management strategy, but he does not agree with them.

> *"There are those who disagree. There is a researcher and consultant at Lund University (…) who usually writes debate articles saying that we have done everything wrong. (…). I do not agree with her on the conclusions she gets from literature and so on regarding*

that no fusions succeed if they are speedy, but rather that there should be a slow and tenacious process. I have another opinion and I know many others who have another opinion of this as well." (Region Director)

Instead the speed in the process is seen as a way of showing decency towards the personnel:

"There are few among us humans who love change, or being subjected to change. We want to decide alone when we are subjected to it and how that change will look. It is very human. And therefore it is very important to be very clear and very quick, in such a process, with what is happening so there are not several other pictures spreading that you have to spend a lot of time to try and handle. So I think it is a process of decency in all contexts. The personnel should not have to read these things in the papers but should get the information directly." (Region Director)

However, all other interview subjects voiced opinions about the merger being done too quickly. This was brought up by doctors and middle managers alike and even among top managers on lower positions. One doctor says that health care organisations should be characterized by slow transformations and certain levels of inflexibility in order to ensure patient security in the same way that hospitals do not adopt new treatment programs on regular patients until they have been thoroughly tested and approved. Changing the health care too quickly could result in drastic impairments that could not be foreseen. We mentioned that others in the organisation had voiced concern about how little time six weeks are in order to merge a hospital of this magnitude, and asked the initiator for comments on this.

"No. For the operating core it was not too short, absolutely not, on the contrary. I mean, the hospital manager was informed and he had already considered how to rig the management organisation et cetera so it did not come as a bomb to him on the 23-24 November. Then you can always discuss whether the political process was too quick or not, that is something I leave to the politicians. From the perspective of the business, from the employees, from an effectiveness perspective, there was nothing to complain about with the speed." (Region Director)

Both among doctors and middle management voices are raised about the lack of using theory:

"My theory is that they have not used any theory." (Middle Manager)

5.4.1.a Managerial perspectives on the use of theories – Discussion

The top management shows a clear mistrust of academia in general when it comes to content and application of theories. They describe the use of theories in a similar way to that often discussed in management fashion literature, where the emergence and disappearance of 'new' organisation concepts are a popular topic (Bender & van Veen, 2001). A management fashion can be defined as a relatively transitory collective belief, disseminated by management fashion setters (Abrahams, 1996). The imprudent following of such fads and fashions can be potentially harmful to an organisation and might cause organisations to leap rapidly from one technology to the next, so that no technology has enough time to work (Abrahams, 1991). These fads and fashions can be the result of a group of organisations' high uncertainty regarding goals and the efficiency of innovations. They are likely to emerge due to outside organisations' high, sometimes coercive, influence. Examples of such outside organisations are governmental regulators or labour unions. On the contrary the fads and fashions can also emerge due to limited influence from outside groups or organisations. This can cause organisations to adopt technically inefficient innovations or to reject efficient ones; it can also cause them to imitate each other's unwise adoption or rejection of such innovations (Abrahams, 1991).

In Swedish health care there has been an ambition to find a "final solution" to all the possible problems that the previous organisational and administrative structures have had, and not been able to solve. This has resulted in a lot of uniform organisational changes during the last few decades that have been affected by administrative fashion and political ambitions (R. Axelsson, 1998). Hence, the risk for the emergence of change fatigue and inoculation, as discussed by Palmer et al. (2009) and Ford, Ford & D'Amelio (2008), is apparent in the health care sector. Hallin & Siverbo (2003) write that there are no longer any self-evident ideals for the organising of the Swedish health care. It used to be dominated by different ideas but is now characterized by diminished confidence for both organisational ideas and organisational reforms. Derisive terms are commonly used to paint a sharp contrast between 'following fashions' and what serious and rational managers are supposed to do (Bender & van Veen, 2001).

In our case the top managers are averse to popular management theories proclaimed by management "*prophets*" and prefer to see themselves as pragmatics. In accordance with management fashion literature this is not surprising and it could also be seen as a wise basis not to jump on fashion after fashion. This view is shared by doctors, exemplified by Olsson (2005) who in a debate article asks when common sense will become a fashion word within health care. In Sweden many of the reforms are derived from New public management (NPM) where different models have succeeded each other and there has been a clear element of fashion where regions and counties imitate each other (Elmqvist, 2002).

However, the top management's emphasis on following the development in the surrounding world indicates that they have looked at what is so common today: mergers. According to Choi (2011) there is no doubt that mergers have permeated all sectors of society leading to a merger mania in the world that reached the Swedish health care sector in the 1990s. Ahgren (2008) writes that the Swedish hospital mergers seem to stem from a conviction among policy makers that bigger hospitals lead to lower average costs and improved clinical outcomes. He writes that the effects of these mergers have not been systematically evaluated. The question is whether it is automatically better to be big. On the SUS "about us" web page the first sentence describing SUS is that it is the third largest university hospital in Sweden (Region Skåne, 2011). This might be an indication of what is valued.

The problem emerges as the mistrust of theories causes management to disregard the studied common outcomes of organisational changes that are discussed in change management literature (Kanter et al., 1992; Palmer et al., 2009). No real theory is considered except a principle of doing it quick, a strategy that research has shown to be controversial at best. Some studies show that speed is good (Jordan & Stuart, 2000) while others indicate that haste does not lead to successful and sustainable organisational change (McNulty & Ferlie, 2004). The top management is influenced by other mergers but neglects studied outcomes of such mergers by asserting that arguments of competence loss is just "empty talk" when there is strong empirical evidence of mergers having the negative impact that scholars have suggested (Schweiger & DeNisi, 1991). Thus our study supports the findings by Berggren & Silfverschiöld (2010) who studied the theoretical backgrounds for the SUS merger. They concluded that there are several indications of insufficient measurements being taken in order to avoid common merger and post-merger problems, something that decreases the chances for a positive outcome.

5.4.2 Focus on the top of the organisation

The merger was a strict top-down process which was a conscious strategy from top management. The decision was kept in a "*tight and quick process*" in order to "*own the information to the affected employees*" (Top Manager) and to avoid this information leaking out to the media. For that reason top management says that they informed neither the media nor the union until they informed the

personnel about their decision. The characteristic perspective held by the management can be illustrated with the words of one of the top managers:

> *"I mean, [the hospital manager] was informed and he had already considered how to rig the management organisation." (Top Manager)*

The speed of the process is mostly referring to organising the top of the hierarchy. The emphasis is put on which top manager is supposed to be at which position. The explanation is that it is important for everyone to know who to communicate with and to know who ones superior is to facilitate communication. It seems to be what has been most important and also the basis for how the success of the merger has been evaluated.

> *"What we have succeeded with is to create a governing function. That is, we have created a governing structure around this, coordinated the different managers in this way. We have done that. And we have created an organisation for the business where we have divisions encompassing several of the hospital clinics." (Top manager)*

However, the middle management thought that the focus was primarily on the administrative level and that there was insufficient focus on the organisation below the top layer of the hierarchy. Middle management thought that the spatial aspect was forgotten, the analysing was not completed and the possible final effects were not considered. This was criticized by several of the doctors who also mentioned that no planning was done regarding the required competence. The nurses with several years of experience from specialized eye care were eventually not brought to the inpatient ward unit. Middle management thought that the mental picture was ok but also that the "solution phase" was not detailed enough. The result was that parts of the business had no way to go when shutting down the inpatient ward unit at one of the two sites. Two weeks before closing down at Lund it was not decided where to move. And when it was decided to move into a shared ward unit with plastic surgery, the ears-nose-and-throat clinic and the breast cancer clinic, they were told that there was no room.

> *"But then a 'strong man' came in and said: 'Now it is like this. They are moving in here now, do you understand?'" (Middle Manager)*

One doctor mentions how the opinions voiced by some of the elder professors on the changes of the business were belittled by top management. According to the doctor the reply to the professors' opinions was: "*professors do not know anything about organisation*" Another doctor mentions that when the doctors were protesting against the decision the reply was that "*if you make any trouble now you will only be punished for it later*". The doctor says that silence was what it was all about and that it probably was the worst reply they could have received. Another doctor says that when they informed the management about all the disadvantages and risks, that these changes would do more harm than good, they were not believed and management saw it as a lack of change potential among the employees. They were told that they were resistant to change. Since those at the bigger, and more developed, clinic in Lund were those who voiced the biggest concern in the beginning of the process it was seen as resistance due to rivalry. Those in Malmö who voiced their concerns about the problems were not as many in the beginning of the process as they realized the problems first later on.

Among the top management there are those who believe that the organisation should be as decentralized as possible and that there are few strategic decisions that should be made by the hospital management alone. However, the fusion work, which is described as "*laying a puzzle with rooms and other things*", must be all-embracing on hospital management level due to the internal

rivalry between the middle managers. We asked a middle manager whether he thought something should have been done differently in the process.

> *"Well… yes I probably think that… I mean, it was a top-down process from the region management, which possibly involved the hospital management. It should have gone down at least one more level in the organisation, in the planning process".*
> *(Middle Manager)*

> *"We were practically only imposed to do things. So we have not really prepared such a process ourselves. We have not had the mission to prepare it but we have been the ones who carry it through. That is how it is. Of course, if we had had the task, Malmö and Lund, to do it in a certain way, with a time plan, then of course it might have been done in another way. Now it was practically from one day to another, it was a really quick process. There was not really any time for any coordination processes or such things. One should also do these risk- and consequence analyses as well, when moving things, according to those rules we have considering the union and such. We have not really, and the Swedish National Board of Health and Welfare have indicated this, that we have not really always managed to keep up with those areas, and that is something that we have also been criticized for." (Middle Manager)*

The top-down approach used included instructions that came from above the hospital manager. They were to involve everyone "*straight across the lines*" and in the instructions it was already decided which units were going to be merged, according to one of the top managers within the hospital.

In an official document on the Proluma web page from March 19, 2008 (Region Skåne, 2008e) it is written that the hospital managers received instructions to leave suggestions for the coordination of the two hospitals. It further says that the following 14 business areas are by the hospital managers specified to be included in the first round and it is also indicated where the primary localisation of each business area should be, either in Malmö or in Lund. For the eye clinic it is indicated Malmö. Further down the document it says what should be done, including task descriptions and analysis. In the governing document for the change work (Region Skåne, 2008c) it is also declared that the selected units will be merged with one management placed at one of the sites and that long-term care and on-call duty is to be focused to one of the sites while a smaller part of the business can be located at the other site if special requirements can be indicated. The documents suggest that it was first decided which units that were to be merged and where they should be localised. The further analysis was to be conducted afterwards. The doctors think that the management should have looked to what the two different clinics were doing, what they were good at, what could have been done better and then tried to make the best out of it instead of, as they see it, arbitrarily appoint locations.

5.4.2.a Focus on the top of the organisation – Discussion

In the Proluma process it seems like important governing details regarding the eye clinic were decided by top management before a thorough consequence analysis involving eye clinic personnel was done, and in direct opposition to a previous investigation. Thus there seems to be an exaggerated belief among the decision-makers in their own competence to make educated and fool-proof decisions without the involvement of those with expert knowledge and vast experience from working within the affected business. The problem with decision-making in complex situations, such as an organisational transformation involving 12 500 employees and affecting 1.7 million inhabitants, is that it is impossible to acquire perfect information about the situation and all possible outcomes and effects. According to Beer, Eisenstat & Spector (1990) it is too risky as a deliberate strategy to start change exclusively from the top, even if it is possible. They write that change is about learning

and that it is a rare CEO who knows in advance the fine-grained details of organisational change that the many diverse units of a large corporation demand. A contributing factor to why so many horizontal mergers rarely are successful is because the decision process naturally is characterized by bounded rationality (Alarik, 1982).

The previously discussed disbelief in contemporary merger and change management literature is probably a cause to what has been experienced as a lack of planning in the merger process. Another cause might be the focus on the upper layer of the organisation and the disregard of the lower layers, the ground floor where the actual business takes place. According to Choi (2011) management at all levels is important for the development and outcome of the merger process. In what Alarik (1982) describes as the coalition process the first aspects that need to be decided when taking the formal merger decision is to agree upon the owner questions, resource distribution and how the top layer of the organisation is to be designed. The problems concerning the actual coordination and the more detailed design are to a large extent transferred to someone else. In the case of the Proluma/SUS merger, however, it seems like the planning process has stopped at that level and that the rest of the process to a much larger extent is guided solely by the speed principle. This principle is both advocated (Jordan & Stuart, 2000) and impugned, at least if implemented in large-scale and simultaneously across the organisation, since it might hinder the establishment of trustful relationships and invoke resistance (Amis, Slack & Hinings, 2004).

The use of a rapid progression of change programs is according to Beer, Eisenstat & Spector (1990) often a result of senior managers wanting to try another change program after previous ones have failed. The problem is that it only exacerbates the problem because they are designed to cover everyone and everything but end up covering nobody and nothing particularly well. There are indications that this might have happened in the SUS merger where the speed was priority and the top management says that the instructions went out "*straight across the line*". Beer, Eisenstat & Spector (1990) proceed by stating that one-size-fits-all change programs causes general managers to not support them even when they acknowledge that their underlying principles may be useful. When Proluma was announced it was practically already decided which clinics that were going to be merged and where their principal placement with inpatient beds and emergency duty would be located (Region Skåne, 2008c). This can be seen as a one-size-fits-all solution considering that the clinics were simply split fifty-fifty between the two hospitals without preceding careful investigations and evaluations. That the general manager of the eye clinic in Lund at that time did not support that change program even though he acknowledged that the underlying principle was useful can be seen in a letter to the top management published on the Proluma web page (Region Skåne, 2008f) where he states that he admittedly would have advocated a merger but not according to those conditions established by the top management. He mentions numerous reasons to why, some of which was discussed earlier in the section '*Perceived results of the merger*.'

5.4.3 Allowing the operational staff to contribute or not

The doctors think that the management should have looked to what the two different clinics were doing, asked them what they were good at, what could have been done better and then tried to make the best out of it. According to one of the doctors the consequence analysis that later was done was forced upon the management by the doctors from below after they had been informed about the merger. The analysis showed that the business should be placed in Lund, which was the opposite of what the top management had decided. Several of the doctors seem to have understood that this was going to be the final decision. But shortly after, the consequence analysis' authenticity was questioned and, according to the doctors and also a middle manager's understanding, this decision was revoked. One doctor says that there is someone with a lot of power who simply has walked in and "pointed with the right hand". In the end several of the doctors from Lund felt that they had been subjected to a hostile take-over. A middle manager admits that the process was

against the will of the entire clinic. Doctors from both Lund and Malmö feel that they have no view of how the process is working and that they have no possibility to contribute or get any kind of response to their ideas or considerations.

> *"They [the top management] have an opinion without having looked at numbers. They have a conception of how some things work and based on that conception they decide certain things and when one cautiously points out that 'your conception is not entirely right, because considering the numbers of patients we have, how much room we need for examination rooms, then we have another dimension here, we have four times as many patients as you had thought and we need a lot more square meters'. And then that information goes up and then the reply is: 'So what?' That is at least how it feels." (Doctor)*

The doctors do not know who is taking the decisions that affect them; the middle managers refer to the hospital manager and the region director. According to one doctor it feels like the decisions are taken very far up where there is no overview or experience from health care. There were some rumours saying that the eye clinic had been subject to a bargain between influential managers. Indications of how the final decision was made after the objections from the doctors can be found on the Proluma web page (www.skane.se/proluma). In a document one influential manager asks a doctor if surgery unconditionally must be placed in Lund if retinal research is placed there. The responding doctor replies that research would not "unconditionally" be worsened in the long term if surgery was placed in Malmö. However, he mentions several setbacks and problems with doing this. He also emphasises that his response only concerns the clinical research and not whether the actual clinical operations such as surgery would be worsened by the move (Region Skåne, 2009d). Another doctor's response to a similar question asserts that retinal research has been conducted without access to inpatient ward beds or operations (Region Skåne, 2009c). However, the project manager draws the conclusion from these reports that it is not proven that neither research nor surgery must be placed in Lund or requires inpatient ward beds (Region Skåne, 2009a). After contacts with clinical managers, the management found no further unconditional demands for immediate time or spatial relation between research, surgery and long-term resources (Region Skåne, 2009e). The final result was that, in accordance with the earlier decision, on-call duty, management and inpatient ward beds were to be concentrated to Malmö (Region Skåne, 2009b).

The main issue for many of the doctors is that they do not understand why the merger was done in such a way. Both doctors and middle management think it would have been easier for the doctors to accept the decisions if they had only understood why the changes were done and what the gains were going to be. Some of the doctors do not to seem to have a general interest in how the business is organised. But there are also those who voiced a lot of general interest in effectiveness and organisation and complained both about other doctors not engaging themselves enough in these questions as well as management's disregard of their ideas and considerations.

> *"If I was allowed to design the business myself I could increase productivity with 50 % by tomorrow, if someone would only listen to me. But no one does." (Doctor)*

5.4.3.a Allowing the operational staff to contribute or not – Discussion

The alternative strategy to strict top-down management is the bottom-up approach where the members of the organisation are allowed to contribute to the change. Studies have shown that the most effective senior managers recognise their limited power to mandate corporate renewal from the top. Instead they define their roles as creating a climate for change (Beer, Eisenstat & Spector, 1990). Top-down approaches can obstruct the optimal integration between service providers (Kodner & Spreeuwenberg, 2002) as well as obstructing the chain of care development. Chances for

successful outcomes are also higher if initiated locally by dedicated professionals (Ahgren, 2007). In health care, incremental or 'hybrid' change within existing organisational forms appears to be more effective than top-down strategies of 'big-bang' change (McNulty & Ferlie, 2004). Weil (2010) argues that those who undertake a hospital merger should make an effort to increase the clinical engagement in the process by encouraging the clinical leaders and practitioners to become far more involved in the merger discussions, their implementation and their evaluation. Donabedian (2003) describes the managerial efficiency as the efficient production of goods and services through the application of various methods, but "*without the participation and consent of clinicians, some of these changes would be difficult to introduce*" (p. 10).

Experiences from change work within Swedish health care shows that the main part of the change work should be done within the units where the actual business is conducted in accordance with the bottom-up approach (Ahgren, 2007, 2008; Choi, 2011). In health care, R. Axelsson (1998) argues, it is required to gain approval for decisions among all the major actors within healthcare, the politicians, administrative management and doctors, as well as involvement and a dialogue between the different levels within the organisation. This is required in order to gain a greater understanding and cooperation between the different actors (R. Axelsson, 1998). The three groups are dependent on each other but there is a lack of trustful relations between them. Much could be won by increasing mutual trust which could increase both the feasibility to govern the organisation with authority, at the same time as it would decrease the necessity for such authority (Hallin & Siverbo, 2003).

Kotter (1996) asks if change is something one manages or something one leads. To manage change is to tell people what to do (a logic of replacement), but to lead change is to show people how to be (logic of attraction). Change is seen as something someone with authority does to someone without authority and the logic of attraction and its power to pull is overlooked (Kotter, 1996 in Weick & Quinn, 1999). By making use of the will to change within the organisation one does not only gain further acceptance for the changes and reducing resistance, it also makes them more sustainable (Beer, Eisenstat & Spector, 1990). Furthermore, since the changes are done in smaller scale, continuously and repeatedly, several different structures can be tested and the most effective system might slowly emerge (R. Axelsson, 1998). This could probably help avoid the risks related to adopting fads and fashion previously discussed. Most organisations have pockets of people who are doing small changes already. The challenge is to make these isolated innovations travel within the organisation to reach a wider range (Weick & Quinn, 1999). We identified doctors in our study who want to contribute to the economic and organisational structuring of their day to day business but they feel like they are not allowed to or that no one listens to them. Several studies have shown that the doctors' interest for these questions have increased due to previous health care reforms (Svenér, 2010; Hallin & Siverbo, 2003). The question is: if that is true, should they not be allowed to be involved in the development of the business they work with every day and have the medically unique expertise for? Alarik (1982) describes how merger results usually get worse if individuals with important knowledge are not consulted, especially since organisational-specific knowledge usually is spread in the organisation and not concentrated to one specific group of people. Hallin & Siverbo (2003) continue by asserting that a corner stone in the medical profession is the desire to develop the operational core business, something Mintzberg (1993) argues is a characteristic of a profession.

In the SUS merger case the doctors have tried to influence the process. They forced the management to initiate an investigation and they contributed a lot to it themselves. As a response to the demands for consequence analysis published documents indicate how managers made inquiries that seem to be much of that kind that Alarik (1982) describes as inquiries as a means of anchoring and legitimizing the decisions that in practice have already been made. Inquiries that serve to further establish a pre-determined decision and the decision following the consequence analysis, which doctors and middle managers perceived as being established and later revoked, are examples of what can be seen as breaches of agreements and failures to restore trust. These are according to

Ford, Ford & D'Amelio (2008) ways in which change agents sometimes contribute to the occurrence of the very reactions they label as resistance through their own actions or inactions.

The consequence analysis was disregarded and concerns were refuted with statements such as "*professors do not know anything about organisation*", and the doctors were accused of being resistant to change. Mintzberg (1993) described how professionals, such as doctors, have a strong professional identity and ownership in professional bureaucracies. Dirks et al. (1996) argue that identity and psychological ownership will lead to positive or negative orientations toward change which explains why individuals either promote or resist change (Dirks et al., 1996 in Pierce, Kostova, & Dirks, 2001). However, by assuming that resistance is necessarily bad, the change agents may miss the potential contributions of increasing the likelihood of successful implementation. Instead, they should use resistance to help in building momentum for change and eliminating impractical and counterproductive elements in the design and conduct of the change process (Ford, Ford & D'Amelio, 2008).

According to Ford, Ford & D'Amelio (2008) reactance theory proposes that resistance is a sign of higher levels of psychological involvement and commitment to the success of the organisation, but is often misinterpreted as simple disagreement with a proposed change. Thus simple acceptance to changes might indicate lower commitment and involvement. Consequently we argue that it would be frightening if the doctors did not react to what they thought was bad for the business and ultimately the patients.

5.4.4 Explanations to the problems

The top management assert that the organising of the top layer of the hierarchy, the management functions, was done quickly and successfully. But they do not think that the lack of preparations that the middle management and doctors have been complaining about falls under their responsibility. Instead this responsibility is ascribed to those further down the hierarchy. We asked top management if they were prepared for the negative consequences that occurred and how they prepared for them.

> *"Yes, you could say there was preparedness. I would like to say that it was a little different depending on different positions, where they belonged in the organisation. We were prepared for it and conscious about this, that it will happen, and then where it happened we could not say. It came already in Proluma at certain different areas: 'here there are troubles'. But if you have read and followed this somewhat, we have a clinic where there has been trouble that is called the eye clinic [...]We have had big and small problems so to speak and some have solved it directly. We were prepared for it but the clinical staff was perhaps not prepared for it." (Top manager)*

When talking about the speed of a change process and people's reactions to it one of the top managers describes the success of the merger as being dependent on the managers further down in the organisation.

> *"I mean, the analysis about why this is done is already done when it happens, so to speak. Then it can become more or less successful depending on how all the managers in the organisation can motivate people to help and yeah, well… speedy but not insensitive yet again. Clear information is what is actually important and that the process is started and that you do not sit and discuss. The silliest thing that exists is really to sit down and discuss if this was good. I mean 'Hello! The decision is made!', and now the result is dependent on what everyone does to help make it succeed." (Top Manager)*

”I think that among these fifteen clinics it was pretty much everyone except a few who did it very well. Though, a few of those who lead it then, the work on clinical level, underestimated some ‘undercurrents’. The eye clinic became a little troublesome.” (Top Manager)

The problems were mainly heavy losses of competence, mostly at the eye clinic but also at other clinics. These are according to the top management due to the rivalry between the clinics and mainly attributed to the Lund clinic and the Lund doctors.

“There has been some kind of antagonism between them where one has looked down upon the university part in Malmö as well. Lund University is just as big in Malmö as in Lund when it comes to the hospital point of view. That aspect was a little frightening I think, it also led to, in some areas, a competence loss, mainly within eye surgery.” (Top Manager)

5.4.4.a Explanations to the problems – Discussion

Top management claim both that they knew and had preparedness for what could potentially become problems later on at the same time as they say that the business further down were not prepared for these problems. This is directly contradictory to the claims of the doctors who say that they did inform the top management but were not listened to and that their arguments were rejected, as discussed in the previous analysis on non-involvement. It is also implying that it does not fall under top management’s responsibility to address these problems and be the ones to solve them. Boeker (1992) had found that poorly performing organisations with powerful top management are less likely to replace their top managers but are significantly more likely to replace those managers reporting to the top manager. He says that the top managers buffer themselves from performance responsibility but "compensate" by replacing managers further down in the organisation in a process referred to as scapegoating. Several managers have come and left during the SUS merger, the eye clinic have seen four managers in the last three years. In our study we have not looked for any signs of management dismissals resulting from scapegoating but we can see indications of the existence of a buffering process in the quotes above.

The buffering is conducted through the shifting of blame from top management to the business and management further down the organisation as well as to the internal rivalry between the clinics. Alarik (1982) writes that antagonism likely is a common element in horizontal fusions, especially in organisations that used to compete against each other. If the leading actors cannot bridge and handle these in a constructive manner they can be worsened and obstruct the realization of coordination advantages. According to Ford, Ford & D’Amelio (2008) change agents can safely attribute problems to resistance as a way of diverting attention from other factors, including their own failures. Thus they might be encouraged to engage in scapegoating and shaking off responsibility by blaming difficulties on resistance.

Choi (2011) found that in the Karolinska Hospital merger the primary challenge for management was to deal with the vertical differences existing in the competing logics between managerialism and professionalism, not the horizontal differences. Considering that doctors in our study from both the Malmö and Lund units are critical to how the merger has been managed and how everything has turned out it seems likely that the existing problems are more of a vertical character than a horizontal rivalry character. Thus the blame-shifting towards those further down in the organisation evokes the question: who is supposed to be responsible? If middle management (primarily the previous clinical manager) and doctors are neither involved nor listened to, should they still be the ones to which the responsibility for the success of the merger is attributed?

After both literature studies and own research Wallenberg (1997) found that the importance of management acts permeates the entire organisation. Management affects individual and collective elements in the working climate, which affects the individual motivation and, in turn, the actual outcomes. Hence the management cannot blame negative outcomes entirely on the middle managers and practitioners but have to acknowledge that they have a responsibility in the actual outcomes as well. In his work '*Management: Tasks, Responsibilities, Practices*' Peter Drucker (1974) studied managers in business and public service and claims that it is management and the managers that will determine our future. The last sentence ending the book says that "*He [the manager] must accept moral responsibility of making individual strengths productive and achieving*" (p. 811). According to Elmqvist (2002) it is the leadership's responsibility to create working conditions that maximize the personnel's motivation and change readiness. In relation to change, Kanter et al. (1992) argue that responsibility for the microdynamics of the development of the change, with structure, coordination and organisation during the entire life-cycle of the process lies in the hands of the change implementors. In their comprehensive exploration of accountability Bemelmans-Videc, Lonsdale & Perrin (2007) discuss the role of accountability in a New Public Management (NPM) perspective. They assert that it is a prerequisite for legitimizing the exercise of authority and that vertically reciprocal accountability is something desirable. However, accountability down the organisation requires the possibility of taking decisions at the level where held accountable, therefore they argue for an accountability that supports bottom-up participation.

5.4.5 An approach perceived as unrealistic and contradictory

From both the middle management and the doctors several interviewees have pointed out that there were several aspects of the strategy and basis of the merger that were not realistic. Some of the doctors' perception of how the decision has been made is that the top management simply has considered the different clinics as blocks that are easily moved together. A middle manager says that the top management had the dream that with two such good clinics, the elite in Sweden, the result of the merger should be that the merged clinic becomes even better. But when that does not happen it is possible that the size and complexity has been underestimated and that it might have been good to ask the employees what they think of it. The effects were, for example, that when moving the inpatient care from one hospital to the other, but not having decided where to move when only two weeks remained, the ward unit that were going to receive them said that they did not have enough room. A middle manager says that the top management did not follow through the solution phase but had the idea that "*things will sort themselves out*". The middle manager claims that the eye clinic is still suffering from these decisions. The following two quotes indicate that the doctors thought the ideas behind the merger were not realistic. The doctors came from one of each of the two hospitals and answered the question whether the management had any preparations for avoiding negative consequences or not.

> *"No. For example, one argument for placing the retinal surgery in Malmö was the fact that before Proluma there were fewer hospital beds in Malmö. This was seen of a sign of more efficient care. Now we see that these beds are far too few. Among surgeons there has been a wish to open up the ward in Lund." (Doctor)*

> *"I think they were quite naive. They thought that: 'We believe the idea was good and that what we want to carry out is a good idea and we think it can end up as something positive' and they have simply said that: 'We do not need to take the blow, instead it is those who work with it that suddenly need to reorganize or work in an unorganised environment'. In any case, I feel that they have not had a really good…well they were not so realistic I believe. They have surely pointed out that there will be a transition phase, they had different phases. But I do not think they really understood how bad the results could be." (Doctor)*

Our interest was not only regarding the use of theories but also the use of experience or inspiration from other hospital mergers. According to studies within the M&A field only 30 % of the mergers are successful. In fact, one of the studies arriving at this conclusion was conducted on hospital mergers (Jordan & Stuart, 2000). There are several other examples of this from other business areas, with failures rates ranging from 46% (Kitching, 1974 in Cartwright & Schoenberg, 2006) all the way to 77% (Marks, 1988 in Choi, 2011), and the healthcare sector is not perceived to be any different (Weil, 2010).The top management are aware of this but have doubt in how to measure a failure:

> *It depends on how you define failure. Often you have industry measurements on this. (…). And you cannot keep Lund and Malmö separately and the merged hospital parallelly and study what happens in the future. You must make assumptions depending on the development (...). Will the relative competitive power of highly specialized care and healthcare research to develop positively? If not, then of course it could indicate that the fusion was not successful. But would it have been successful if you had not done it? What it is about is to not be afraid of facing the challenges of the future. (...). Things can be managed it a good and a poor way, I am sure that there are several fusions that have been managed very poorly. (Top Manager)*

Among the doctors some have heard about how many mergers fail, while for others it does not seem to be known. However, they compare the current situation to previous mergers in Göteborg and Stockholm that are widely known among them, and the Helsingborg-Ängelholm merger was also mentioned. When either doctors or middle management brought these up they were referred to as failed or partly failed processes, with major problems and reorganisation after the merger. One doctor experienced it as if top management thought of the SUS merger as "*third time's the charm*" and said that it "*almost felt a little irresponsible*". The top management says that they have "*followed the development in the surrounding world*" and at least tried to learn from what was done in Stockholm and Göteborg, where one of the managers say there were several problems. But all the top managers say that it is mostly their own vast experience during their careers that they have used. However, middle management and doctors believe that top management has underestimated the size and complexity of eye health care:

> *"For them we are a small unit. There are probably many who image that we are testing glasses, which we do not do anymore, the opticians do that. In the 60s we used to do it." (Middle Manager)*

The need for maintaining the many inter-personnel networks was also mentioned. Within the clinic there are several subspecialties where there are one or very few doctors who are the only ones who have this special kind of competence and who have established complex networks both within and between other clinics with other specialties, such as child care, child rheumatology and trauma.

On different levels in the organisation there are also different views on how to interpret the fairness or unfairness of the merger. When talking about successful or unsuccessful mergers one of the top managers explains that it is not a good idea to have a winner and a loser:

> *"Out of a shareholder perspective, that is where a fusion is never a merger between two equal parts but there is always someone who uses it to increase the value of his shareholder's shares. One does not care that much for those who are shareholders in the purchased company. There is a winner and a loser in such a situation, and I think that would be problematic here" (Top Manager)*

However, on the clinical level the doctors see this in the opposite way:

"It would be better if they took care of what is good and not only appointed one clinic to be the loser clinic and the other to be the winner clinic on all places. I think that is predestined to fail. Maybe it works within the manufacturing industry, I do not know, but not with doctors." (Doctor)

When concluding our findings of the managing of the merger, there is a quote that in a good but rather subtle way describes the perspective held both by the top management as well as how the doctors believe the top managers have been thinking:

"First you do an analysis of what kind of changes you want to do. Then you design how you want to do it, that is, what is the solution to accomplish what you want to accomplish." (Top Manager)

5.4.5.a An approach perceived as unrealistic and contradictory – Discussion

The use of realistic and non-contradictory discourse and arguments ought to be an important factor in how the doctors perceive both the success of the merger and management's trustworthiness. Trustful relations between managers and employees are lacking in health care but are desirable for the health care's future development (Elmqvist, 2002; Hallin & Siverbo, 2003) as well as in mergers in general (Alarik, 1982). By communicating early and often to everyone involved with a realistic assessment of the facts rather than being overly optimistic is one of the success factors identified by Camara & Renjen (2004). Simply communicating frequently and enthusiastically is not enough since there is a risk that the employees might interpret this wrong and accuse the change agent of misrepresenting the change and its outcomes. This can be avoided by being as realistic, truthful and accurate as possible when describing the change (Ford, Ford & D'Amelio, 2008).

Dysfunctional outcomes are avoided or at least reduced by realistic communication and previews in such a way that it helps employees coping with uncertainty (Schweiger & DeNisi, 1991). Sometimes managers tend to be overconfident in, and overenthusiastic about, merger outcomes which may prohibit a realistic identification of relevant aspects. It can also prohibit a holistic view of the organisation which in turn may contribute to failed mergers (Seth, Song & Pettit, 2002). Demands perceived as unrealistic by the doctors have been identified in other hospital mergers as well, such as in the Sahlgrenska University Hospital merger in Göteborg in 1997 (Olafsson, 2008).

According to Posnett (2002) the optimal scale of an emergency care hospital depends on the interaction between the health care needs of a local population and the extent of interrelationships between specialties within the hospital. The concern shown by the doctors concerning the destruction of networks such as those with child care, child rheumatology and trauma indicate a perspective where the design of formal and informal relationships is not seen as realistic. Hallin & Siverbo (2003) describe how the networks are dependent on mutual trust and reliance within healthcare. To destroy both the formal relationships, e.g. the geographical closeness to the child care in Lund, and the informal relationships built on individuals' accumulated experience and trust for each other, might create operational inefficiencies that are both hard to measure, evaluate and identify.

A paradox in the eye clinic merger is that despite management's awareness of the problems with appointing a winner and a loser in a merger, this is exactly how the doctor's perceive it. On the top management level it is naturally seen as a merger between two equals. The emphasis of maintaining it equal results in the previously discussed exchange of clinics between the hospitals based on hospital fairness instead of what is best for the business. The paradoxical result is that on the clinical

level it is not seen as a fair merger but rather that the smaller clinic in Malmö absorbs large parts of the prestigious highly specialized care conducted in Lund, on unclear grounds.

The key to what doctors describe as an unrealistic approach might be explained by how the top management seems to think that a problem should be solved: "*First you do an analysis of what kind of changes you want to do. Then you design how you want to do it*" (Top Manager). This sounds rather plausible, especially considering management strategy literature that assert the importance of developing a strategic vision early in the strategy-making process followed by setting objectives (Thompson, Strickland & Gamble, 2007).

However, vision can also hinder effective change if an emotional appeal is used as the basis for engaging in organisational change. This might cause negligence of necessary attention being paid to operational details that are needed to make the change work (Palmer, Dunford & Akin, 2009). Generated enthusiasm may also cause emotions to lower risk-aversion and the insufficient attention being paid to possible negative consequences. This is because the collection of relevant information that would reveal the weaknesses of the radical vision could be prevented by enthusiastic emotions or a leader's strong charisma (Beyer, 1999). Possible advantages may be exaggerated, especially if the leader has contributed to or influenced their formulation (Ibid.). There is also the risk of senior managers' commitment to a vision making them unwilling to re-evaluate its utility and relevance (Palmer, Dunford & Akin, 2009). In sum, by failing to recognize the limits of what can be known about the future one is likely to race off in the wrong direction (Hamel & Prahalad, 1994).

The pre-established objectives of the placement of the management, on call duty and inpatient ward units of already selected clinics that was described above in the '*Focus on the top of the organisation'* section indicates that what was desired preceded what ought to be best for the operational effectiveness, evidenced by the failure to consult the affected clinics with their operational-specific expertise. Thus, establishing the vision and objectives of "*what kind of changes you want to do*" prior to consulting the medical expertise and establishing what would be best for the operations and the patients, might have created obstructions to an effective organisational change.

5.5 Efficiency in Day-to-day Operations

This chapter deals with the different views on effectiveness and efficiency. Hence, it covers the more abstract ideas, rather than their direct relation to the merger, which is described in more detail in previous sections. The first part of this chapter begins with a general reflection on the contrasting views on efficiency displayed by doctors and managers, relating ideas such as production per time unit and quality of care. The second part of the chapter evaluates more in detail the doctors' and managers' perception of various concepts, or aspects, of efficiency required for effective healthcare. Examples brought up below are job specialisation, technical support functions, patient processes and organisational structures.

5.5.1 Contrasting views on efficiency

It seems that, as when measuring quality, efficiency in day-to-day operations is not so easily defined. One top manager reasoned that, in health care, there are probably as many definitions as there are people. In general health care is defined along parameters determined by the doctors and:

> *"There is a risk and a tendency to have a narrow perspective; you see only yourself and the patient" (Top manager).*

The same manager admits that some of the measures in place are not optimal. However, lacking better alternatives one has to use those that are available. Thus efficiency is defined not from the clinical end points, such as how many patients were able to return to an optimal way of life, which is difficult to define, but rather in the form of how many successful operations have been conducted with few or no complications. Another manager proposes that since the hospital mission is to produce clinical health care, research and education, efficiency would simply be the production of either of these three per time and resource spent. However, there is also a quality aspect in there, working through 20 operations each day would not be efficient if that generated many complications or relapses requiring further operations. The quality aspect was also mentioned by a middle manager, but from the patient's point of view that the accessibility to health care must be improved.

> *"Much energy is spent on making sure that patients do not need to contact health care in person. Much time is spent on talking about what can be done instead, on their own, and what can be done later, instead of spending resources on those who do come in." (Middle Manager)*

The same manager also defined efficiency as external or internal efficiency, that is to do the right things, or to do things right. Right things could be to focus on the needed health care while doing things right could be, as the example above, about prioritizing funding or patient contacts.

Many doctors seem to favour a definition similar to this, in that it could be seen as production per time unit, but that quality has a stronger impact. It should be prioritized to let doctors do their best in every case to minimize complications and relapses, instead of focusing, as has been the case, on clearing patient queues as quickly as possible and make sure that they serve the patient in the best possible way. Also, in addition to the tripartite production mentioned above, one doctor adds administrative tasks as a fourth since a great amount of a doctor's time today goes to such tasks as record-keeping, operation planning, dictation and journal-keeping that previously, to a greater extent, was handled by secretaries.

The groups were also asked about how they believed the other group to define efficiency. In general, the answer was slightly different than the picture put forward on their own, showing somewhat of a misunderstanding between doctors and managers in general. Most managers gave a picture of doctors as concerned only with their own time, to be able to "punch out at lunch on a Friday" and

make their research committee meetings and conferences and do a little doctoring when called on, that they did not see the big picture that care had to be given to a larger amount of patients. One exception to this is one top manager who believed that:

> *"They want to perform their job in an uncomplicated way in the environment they are in, that they do not have to find ward places, that they can avoid things that do not create value for the patient." (Top Manager)*

Doctors, on the other hand, saw management as number crunchers, concerned only with the volume of care that would guarantee further funding and a good ranking, that it is all about getting the money's worth. They prioritize along purely financial incentives, getting part of government bonuses such as Kömiljarden and Vårdgarantin. Thus focus is on operations that are really quite simple, such as cataracts, with fewer long-term complications than, for example, glaucoma, but that are quickly operated and thus generate more funds from the bonuses. The negative effect of this is that other diagnoses are less prioritized, even though medically they should have a higher priority, and it also puts a volume requirement on doctors.

5.5.1.a Contrasting views on efficiency – Discussion

As mentioned in the theoretical chapter of this paper, there is no one way of defining the concept of efficiency or effectiveness. Consensus has it that the concepts are sometimes closely interrelated, and sometimes not. In some cases the one is clearly more relevant than the other, but in other cases they may be used generally.

It seems that managers favour a definition where the outcome is measured as production per time unit, or resource, spent. This seems closer to that of efficiency (Donabedian, 2003), in that the goal is to keep resources constant while increasing or maximising output. Managers also mention the quality aspect, but with the simple meaning that the goal should not compromise the quality of care given measured in number of complications or relapses. This is in accordance with Elmqvist's (2002) results that while maximising output the quality must at the very least remain level to be efficient.

In contrast, most doctors mention that a measurement could be production per time unit, but more important is the overall quality of care. This is closely linked to the concept of effectiveness (Donabedian, 2003), in that it demands the maximum improvement in health given the constraints of the present situation. The doctors also maintain that a certain volume of output should not be demanded of individual doctors, as is often the case because of the way the system is funded. They should instead be focusing on achieving the highest possible quality of care, and the volume should be demanded of the system in general. That is, the output volume required of the hospital, governed by public demand, would likely cause variations in the number of doctors employed, rather than the number of procedures conducted by each doctor.

In the case of funding health care, the system is built on a pay-per-performance idea. Health care providers are financed depending on the amount of care given, defined through the DRG-points described in the chapter above. The completion of certain targets, such as reduction of patient queues (Kömiljarden) and supplying care within a certain time frame (Vårdgarantin) ensures further funding (Governmental Offices of Sweden, 2011). The result of this seems to be a distinct focus on output volume relating to these targets, rather than the quality of care given, thus legitimising the definition maintained by management at the hospital.

5.5.2 Aspects of effective/efficient work

Efficient day-to-day work in health care is dependent on many things, below are some of the most prominent factors of efficiency mentioned by several of the doctors in our study. We have categorized these responses into five themes: Technical support functions, Job specialisation, Inter-personnel communication, Process and timing and effective organisational structures.

5.5.2.1 Technical Support functions

The problems with the supporting IT-systems' complicated and inefficient structure was mentioned by several doctors. Apparently, there are different journal- and patient planning systems used by doctors, nurses and secretaries, such as Melior and PASiS, resulting in much work duplication and time lost, both in adding and editing information and also when retrieving it. Melior, the primary physician database for patient journals is standardized for the entire hospital. It has a plain text layout which is not suitable for the eye clinic which has a need mostly for data points tracked over time to evaluate deteriorating circumstances. This means much data is penned by hand in long lists that takes a long time to find afterwards instead of building a program on columns of data displayed in a diagram. PASiS is an administrative patient planning system used mainly by nurses and secretaries to plan the patient process. When introduced, workload was expected to go down so the number of secretaries was reduced. However, the workload drop was far lesser than expected which increased the remaining secretaries' work burden and several of them resigned, says one doctor. Also, Lund and Malmo hospitals had different systems and practices which have not yet been completely integrated. Problems still occur at SUS due to the differences of the two constituent hospitals. A similar notion is held by one middle manager, who mentions that:

> *"Our so called support instruments from the IT-side give little support to the doctors in the patient process; they are designed only to document. Coupled with compound errors during dictation, transcribing and journal input this is not effective." (Middle Manager)*

5.5.2.2 Job specialisation

Almost all doctors mentioned the importance of good support functions in place in their clinic in order to get a good work flow, with quick and efficient switching of patients and post-op work. Managers also agree that higher efficiency will also be achieved by:

> *"Removing non-value adding time, such as documentation, searching for information and transportation in the patient process. Doctors should not have to run between different places and support must be available and effective, such as someone helping with documentation." (Middle Manager)*

A doctor expressed this clearly in that specialization is seen as the premier tool for efficiency, that doctors do only what they are specialised in. One doctor operated 15 patients per day while working at another hospital, where there were two specialist nurses assisting. When working at SUS, such support is sometimes missing and seeing ten patients a day is considered good productivity. Another mentions that while working at a different hospital with readily available secretaries and specialist nurses, 18-20 patient consultations were handled each day. At SUS the average was 8-10 per day as the doctor had to fetch the patients, have the consultation, dictate and import to journals and handle calls individually. A related function here is secretaries, who used to assist with dictation and transcribing patient journals, scheduling etc. According to doctors they spend approximately 30% of the day with administrative tasks which could be handled by secretaries. This situation causes a

stressful environment, since there are directives from above on how many consultations should be cleared, in which communication with the patient may suffer and not all information is relayed, resulting in renewed visits or calls just to get a little extra information.

In general, both managers and doctors agree that job specialisation would increase efficiency:

> *"Have the right person in the right place. You shouldn't do something that another person on another schedule with a different salary can and is hired to do. It's the same thing with cleaning the office space as well. Why not hire a cleaner to do it, and I can see more patients until I go home." (Doctor)*

In relation to the recent reduction of secretaries and specialist nurses, one doctor says that:

> *"You don't save money on laying off secretaries, only on increased productivity. This is what they do at private hospitals, so we know how to do it. Why not do it here as well?" (Doctor)*

5.5.2.3 Inter-personnel communications

A second aspect agreed upon by a majority of doctors is that of efficient inter-personnel communications. Many diagnoses have a varied spread of symptoms and complications that may expand beyond the borders of one specialisation, such as retinal surgery sometimes encountering issues relating to the visual cortex, a facet toward neurosurgery. Doctors find it critical to efficiency to be able to discuss this with the relevant colleague:

> *"Currently, we have to send patients by referral to other doctors and clinics, previously we could just catch someone walking down the hall, discuss the situation or have him/her look at it and solve it directly. Especially relating to the eye there are many small things you have to look at, and it is difficult or cumbersome to describe it all in text." (Doctor)*

This relates also to the education of doctors during the residency/specialty selection (ST-tjänst). When there are residents at both sites they may not be able to take the time to travel more than an hour one day to see a case at the other site and in many cases the dialogue between colleagues is the best way for seniors to transfer their knowledge to juniors and similarly to medical researchers who need access to the clinical cases. In short, accessibility is stressed by doctors. These formations of knowledge clusters are also acknowledged by management, in that they can help promote innovation and increase efficiency. It is also a strategy to direct these clusters to form where they are most needed, as in moving clinics that can benefit from such clusters closer to each other.

Doctors also emphasise the need for a coherent and consistent communication of goals and targets, to provide something to work towards. This can be seen in every day work, for example when it comes to prioritisation of patients. Lacking such consistent targets could lead to a sense of dejection and less engagement with work, resulting in a worsening of work environment and lessened constructive communication between colleagues. This could happen due to any type of change, and an example related to the current merger is mentioned by one doctor:

> *"Previously we had meetings every week, and it was a natural thing for everyone to go, now people just do not care anymore, they are tired. If someone didn't go earlier, people noticed, now no one pays any attention and there is a general feeling of non-engagement" (Doctor)*

This lack of attendance at weekly meetings means less information exchange and communication. Also, geographical closeness is stressed as important to get people to attend these meetings. Few would consider travelling any excessive distance to attend these meetings, which are in essence voluntary. A result of this non-attendance at meetings and generally lessened communication between units of the clinic, and doctors working at the different sites, is that it has lead to mistrust between the different units. One doctor mentions that when employee morale and working environment drops, you start questioning more things.

> *"You are working at different sites and then you think that [the others] aren't doing anything, and they think we aren't doing anything. […] You wonder, he has five patients and I have 8. But is it really true that he only takes 5 over there? There are many rumours like this." (Doctor)*

5.5.2.4 Process and timing

One of the greatest inefficiencies identified by both doctors and management concerning work processes is the preparation time of surgery, leading to downtimes during the day.

> *"Downtime is for example after you have operated on a patient that patient has to be dropped off, you have to clear the room, clean everything and set it up with new sterile equipment. It can sometimes take up to an hour to make a switch like that. […]You never know when that hour will come so you can't plan an extra consultation for that hour either. Basically you wait, maybe make a phone call or check up on a previous patient, but there is quite a bit of downtime." (Doctor)*

The doctor also comments that abroad they often have more nurses and operating rooms, so the doctor simply makes a round operating efficiently all day. One manager specialising in process flows corroborates this account, and adds:

> *"I have been a doctor as well, so I know how it is to sit there thinking: Do I really have to stand here waiting because the anaesthesiologist is so slow, can't I get in there already? Or why is the next patient not on time from the ward? And they ask why the doctor is not on time for surgery? There are many instances of this" (Top Manager)*

However, the problem may be more dependent on the natural flow of patients, and may not be so easily affected. One doctor says that often times, efficiency is not solely dependent on the speed of operation room set up but rather on the flow of patients:

> *"When you have an even flow and everyone have an even work pace, not when you sit two hours rolling your thumbs, then you work really fast for two hours and then it's back to rolling your thumbs, that's what I think is efficient. An even flow." (Doctor)*

Added to this is the way scheduling is done on the clinic level. Most of the time, the doctors have big influence on when to work and when to use the time for other purposes, such as vacation, research and seminars and conferences. According to one top manager, the consultancy firm ATD Little was brought in to investigate possible bottlenecks in production, and they directly pointed to the scheduling system, including concerns that operating clinics were sometimes closed as early as noon on a Friday for no apparent reasons. The manager points out that there should not be less time for research, which aids the development of the field and the region, but rather that it should be better planned in accordance with production requirements.

One manager adds that the availability of ward spaces is sometimes a problem and the system of admitting patients for observation to the wards is unrefined:

> *"In every single case a discussion sometimes starts, that could be repeated several times a day, instead of making sure everyone knows exactly who should be placed where in every situation" (Middle Manager)*

This problem is escalated by the fact that sometimes patients are admitted unnecessarily, as stated by one doctor:

> *"There is a big difference depending on whether you admit someone for post-op observation or not. For some surgeries you lose money if you do not admit the patients because you do not get as much money for them." (Doctor)*

A further issue mentioned is with the queue system, and the governmental stipend 'Vårdgarantin' which states that all patients referred to specialist care must be attended to within 3 months. In contrast, one doctor mentions that:

> *"The patient sometimes wants to wait longer than the guaranteed 3 months. […] they don't want to do it straight away. […] Previously we asked the patients if they wanted to be placed in the guaranteed queue, some of them said no voluntarily because they didn't think it was an emergency. But the politicians didn't want that, so now all are placed within the guarantee automatically." (Doctor)*

5.5.2.5 Effective/Efficient Organisational Structures

Finally, some relevant organisational issues are presented here, such as the on-call organisation, the relevant level of patient care, spatial arrangements of clinic units, incentives for building efficiency, clear financial priorities and, finally, the progression of Lean Healthcare.

While most agree that centralizing on-call and emergency care is good for securing critical volumes in certain specialties, several doctors mention clear drawbacks when on-call staff is not specialized in eye care. The result from having non-specialist trained staff is that the on-call doctor will be called in more often to advise on-site, which means higher costs due to the pay increase during the night. Coupled to this is the issue of whether the patients should be handled in the primary care level or the secondary, that is, in the local health centre or at the specialist care of the hospital. Many times, the primary care centres are overcrowded also with the simple type of procedures they are supposed to handle, so things not really requiring specialist care gets sent to the hospital clinic anyway. The problem with this is that it costs much more to treat the patients there than at the primary facility since the on-call doctors have to be called in again.

Further, the spatial arrangement of the clinic is important as it affects travel time for doctors and patients. If the different units of the clinic, such as consultation rooms, operating rooms and patient care wards, are spread out this means quite a bit of time gets lost on travel. Currently, one doctor mentions an example where it can take more than an hour moving from one location to the next, owing to the sterile requirements of the environment, an hour that could be spent on patient consultations.

Also, the incentives for improving health care are missing, according to a few of the doctors. There is a general salary structure for the public health care with the effect that the only time employees

have to negotiate for a higher salary is the commencement of a new employment. There is little or no consideration for a premium on performance or competence. The result of this is that some newly employed doctors have higher salaries than their seniors who are still involved in training and educating them. As stated by one doctor:

> *"What are the incentives for improvement? What are the incentives to do a better job, to cram in those extra few procedures, to build a more efficient organisation? Sometimes we used to work really hard until late into the evening, but we didn't get anything for that. The same goes for nurses too, who compared to us, have an even worse salary." (Doctor)*

A closely connected issue is that of unclear financial priorities in the organisation. Apart from the previously mentioned issue with patient queue priority, a couple of doctors also mention a recent development in countering age-related degeneration of the retina, the drug Lucentis. It is vastly more effective than previous treatment, and thus has quickly become standard. Unfortunately it is also very expensive, averaging about 10 000 SEK per injection, and a minimum of one per month for three months are prescribed. The result is that a few resident positions in the clinic have had to be removed in order to afford these treatments and since these doctors also treated other types of patients, total production has decreased.

One thing that all doctors agreed upon was the need for consistency in communication when it comes to future plans, and general goals and mission of the organisation. As exemplified with the merger, one doctor believes this lack of communication is directly related to a decrease in employee motivation and morale:

> *"I think the purpose was never clearly defined, you have to decide that this is what we are going to do; now there is no clear picture of expected outcomes toward which we work. Rather it's up to oneself and it demands a lot of engagement. Like from the start we thought that large parts would move out [from Lund] but that has not happened. Now the house in Malmö and the one in Lund are to be demolished so we don't know how it will look, and that makes it difficult to feel engaged in your work." (Doctor)*

A concrete aspect of how to organise is the Lean Healthcare program incorporated prior to the merger, in 2007. This was communicated clearly as the way to go forward. One manager even mentions that the only reason he agreed to join the organisation was because of their apparent engagement with these ideas. A key point of Lean is to build efficient processes designed around the service, or in this situation the patient. In contrast, doctors note that the Lean philosophy has not yet completely penetrated daily operations:

> *"This is the opposite of Lean, with patients being sent to different places and they can't do all consultations or operations in the same day because it's in different locations and such. " (Doctor)*

> *"If you look at patient- and health care efficiency we are supposed to do as much as we can at the same time, that's not how it works now. For example with patients with cataracts and glaucoma you examine their field of vision, to the sides, that is rarely done with a doctor. Instead the nurses feel it is more efficient for them to have their own appointments with patients to do this. But from mine and the patient's point of view it would be good to combine them. […] What people are afraid of is patients sitting in the waiting room a long time. But if you decide to do it all at once, you can inform the patient that maybe they will have to wait for an hour and a half, and if they know that they are ready for it and it doesn't bother them as much." (Doctor)*

5.5.2.a Aspects of effective/efficient work – Discussion

5.5.2.1.a Technical Support Functions

The demand for stronger support functions from doctors can be understood in several ways. In one sense, it is in line with Porter's Value Chain model (1985) in that the core business, comprising logistics operations, marketing & sales and service take precedence in the chain and are supported by infrastructure, HR, technology and procurement. In the present case, doctors inhabit a role in operations, while the journal- and patient planning systems are part of the technology support. Another way of looking at it is with the Lean production system, spawned by Ohno and Shingo through the Toyota Production System in Japan, and popularized in the west by Womack et al (1990). One of the pillars of Lean is to standardize the workflow and eliminate waste in the process around value creating activities, defined as the value desired by the customer (Proudlove, Moxham, Boaden, 2008). In the present case, it could be argued that the value desired is, for example, a surgical operation completed without complications in a timely fashion, where the patients is adequately informed of the process and outcomes. IT-systems in Lean are supposed to assist in the value creation just as any other function, but are often complicated in build and "fat" (Raman, 1998). They often include any possible function, which may compromise overview and usability. The same can be seen in this case, where the IT systems are noted for documenting rather than supporting, and much time is wasted on adding and retrieving information in a complex system. This is the case even though many researchers stress the importance of a well conceived IT support system (Elmqvist, 2002; McGuffog & Wadsley, 1999).

5.5.2.2.a Job specialization

Job specialisation is seen as a form of concentrating competence, enhancing development and thus improving effectiveness and efficiency. This idea goes back as far as the work of Adam Smith and the wealth of nations (1776, in McGuffog & Wadsley, 1999), stating that the division of labour, and thus job specialisation, increases productivity and consequently unit cost of production, making it more efficient. The reason for this, argues Mintzberg (1993) is that through repetition the employee gains experience, rationalises the process and may improve it through new processes or tools. The doctors in this study argue that a return to more specialised tasks may improve efficiency through the elimination of peripheral duties and administrative tasks that could be handled by nurses, orderlies and secretaries instead. Especially in the case of administrative tasks there is a clear economic gain because of the salary difference of about 30,000 SEK per month between a secretary and a doctor, or about 180 SEK per hour of work. This would increase the potential productivity, and it is argued that while some additional nurses, orderlies and secretaries would have to be employed, their lower salary has less of an impact on costs than the resulting increased revenues. This is possible because of the current national funding system in place, discussed below. Argyris & Schön (1978, in L. Axelsson, 2000) argue that highly specialised care deals with complicated problem solving of an extreme nature that must be conducted in an autonomous environment, in accordance with professional literature discussed in a previous chapter. This is because the field is dependent on science and accumulated experience in areas that cannot easily be managed in detail. In contrast, one concern voiced by doctors is that management tries to interfere too much in the aim of controlling output volume which has a negative impact on patient consultations.

The general problem with job specialisation is that it requires greater efforts in communication and coordination of the organisation. Also, it could lead to lessened employee satisfaction as they see their field, and areas to influence, decreasing (Mintzberg, 1993). To offset this, specialisation is sometimes followed by job enlargement, where you add new tasks and responsibilities. This seems to have been what happened the past few decades, where doctors, nurses and secretaries

exchanged tasks and responsibilities and, to some degree in the case of secretaries, reduced presence in the organisation. It follows from this that if an increased specialisation were to occur, any resulting improvements in employee morale could be temporary and, in the long run, lead to a call for job enlargement yet again.

5.5.2.3.a Inter-personnel communication

The problems relating to communication between employees in the organisation is closely connected with the ideas of an organisation built on internal network discussed by Hallin & Siverbo (2003). The network is made up of closely connected relations between employees with a self-regulating control mechanism through mutual understanding and trust. In this network, employees are depending on each other to solve complex problems and fulfil the service to patients. Geographical closeness between doctors is one thing that is stressed as a prerequisite for effective communication, and an efficient organisation is dependent on good communication (Olafsson, 2008). This is also in line with the Lean reasoning, described above, that anything improving value creation should be enforced and waste, such as travel time between sites and writing up documentation for referring a patient to another site, instead of being close enough to discuss it at once. With a lack of insight into the workings at the other sites, some elements of mistrust have also developed. Since trust is central in the network organisation, this makes it even more difficult for new networks to be built.

The doctor cited above also mentions that people are tired of constant changes, which has lead to a feeling of non-engagement with work and deteriorating communications. This seems to be a sign of excessive change, or what many label initiative fatigue (Palmer et al., 2009), which can be defined in two forms. The first is where the organisation carries out many changes at once, seemingly contradictory or unrelated. The second is where a rapid succession of changes occurs over time, and personnel feel that resources are spread thin without effect. In our case, it seems that some of both occur. An example of the first form is that many have the feeling that Lean was at first promoted as most important, but has later been toned down. The second form can be seen in the statements that changes occur constantly, in where units of the clinic should be placed, how many ward spaces are available and different targets of the merger evolving over time.

5.5.2.4.a Process and timing

Issues with process and timing identified relate to inefficiencies in the work processes of the doctors and the way schedules are set. The inefficient work processes are largely about downtime between operations, but also that there are uncertainties in how, and where, to admit patients for observation in patient wards. The inefficient work processes can be related to the Lean production system, or Lean Health care, mentioned above. The key is to design the process around the service to the patients, and eliminate waste. In this case, the variability in demand causes an uneven flow. Raman (2008) argues that instead of organizing functionally, activities should be aligned in a continuous flow to minimize sub-optimization. We would like to note that this should be possible with elective surgeries, however it is more difficult to attain in emergency cases. Also, as opposed to manufacturing industries, demand cannot be manipulated with a reduction of cost/price, as it depends more on when patients experience ailments. Hence, a perfect flow of demand will be impossible to manage, and a clearer focus on an effective process from when the patient reaches the hospital to when treatment is completed should take priority. Another, similar, opportunity to analyse this is through the use of business process reengineering (BPR). BPR places focus on understanding customer requirements and performance measurements, enabling cross-functional teams and communication and process mapping and reconstruction in order to suit the final needs of the organisation and customers (Al Mashari & Zairi, 2000). A key distinction between Lean and BPR is that BPR places greater focus on the IT systems available and what use they can contribute. The ineffective structure of the current IT-system at SUS may be a hindrance when considering BPR,

nevertheless the idea of constructing processes around the service, and eliminating waste, remains applicable to this study. An example where direct benefits may be realised is the scheduling. At the moment, according to managers and external consultants, doctors at SUS have too much say in how the scheduling is done. Redesigning this process centralized on production of patient care and servicing the needs of the patient, prioritizing research time and conferences lower, could allow a more level flow of production and more efficient processes.

5.5.2.5.a Effective/Efficient Organisational Structures

Finally, some relevant organisational issues are presented here, such as the on-call organisation, the relevant level of patient care, spatial arrangements of clinic units, incentives for building efficiency, clear financial priorities and, finally, the progression of Lean Healthcare.

The organisation of on-call capabilities was one major point brought up by doctors. The argument is that non-specialist trained nurses on night shift means the on-call doctor has to go to the hospital more often during the night. This is inconvenient in several ways. First, more frequent attendance at the hospital means reduced sleeping time for the doctors. These precious hours are undeniably needed since on-call is done outside of regular working shifts, meaning they work during the day as well. The night-time nurses do not since they are placed on a simple scheduled night time shift. Second, while being on-call at home costs very little, as soon as the doctor is called in, the pay increases markedly. Consequently, a doctor may be paid for a full hour's work, including travel and consultation time, several times per night for something that a specialist nurse could have handled on the spot. Doctors are aware of this waste, which shows a higher concern for economic factors than attributed to them by managers, in accordance with findings by Svenér (2010).

Regarding organisation of the clinic, the spatial separation of units at different sites was mentioned as important. Results from having a spread out clinic can clearly be seen in the increased costs from travel and timing inefficiencies. This results in less time for patients which in extension could mean longer waiting times, a problem well documented by Fölster et.al. (2003).

Further, problems are identified in the incentives structure, both regarding hospital funding and the employee rewards system. Doctors feel that their medical expertise is sometimes overlooked when it comes to prioritizing patients because the hospital focuses too much on output as a result of the national funding system. The two programs are Vårdgarantin and Kömiljarden (Governmental Offices of Sweden, 2011), the first stating that all patients referred to specialised care must have access to a consultation and treatment plan within 90 days. Kömiljarden states that hospitals who cut their patients' waiting queue to achieve at least 80% success toward Vårdgarantin each month receive a share of one billion SEK. Some doctors argue that this forces the hospital to favour such treatments that quickly reduce queues in response to the incentives, and other patients may be prioritized lower, even though they are medically more in need of rapid treatment. This type of output control can be seen as a rational solution to some problems of management (L. Axelsson, 2000). However, the problem is that in politically led organisations, such as the public health care, some goals are favoured above others that are not to easily measured. Also the premise that goals can be fulfilled through centralised managing and decision-making is also questioned. It has also been noted that this type of management has had little long term effects on production in Sweden, consisting rather of short term increases in productivity that later disappear (L. Axelsson, 2000). Kirchhof (1974 in L. Axelsson, 2000) argues that there are three components to output control: formulation of goals, involvement of personnel in decision processes, and that the goals should always be possible to achieve. This is most effectively done with a decentralised division of labour and high degrees of autonomy, with the support of hard and soft data, i.e. both numbers and, for example, employee satisfaction (L. Axelsson, 2000). L. Axelsson (2000) also argues that such control also demands good knowledge of work processes, how they relate to each other and what is essential for the outcome.

In our case, doctors argue that management has very little insight into daily work, which may explain the current negative mood and low morale mentioned by many.

Performance related pay was sought by some doctors, as noted above. Incentives for 'going the extra mile' seem to be missing for some. Leopold & Harris (2009) note that the main idea behind the concept is that monetary incentives acts as a motivator to increase performance. They note that "unless the financial rewards available are perceived by individuals to be sufficiently attractive and worth the effort needed to achieve them" (p.230) they will not encourage improved performance. Dowling & Richardson (1997) add that performance related rewards had little effect in a study in the British health care if employees perceived objective setting and evaluation to be done inappropriately. The doctors in our study maintain that in certain cases, such as the one quoted above with working to clear patient queues, should have a benefit attached. An argument brought up against this type of system is the difficulty in satisfying many different perceptions of performance (Leopold & Harris, 2009). However, we argue that in this case, the definition is quite simply a matter of overtime hours, or extra surgical operations conducted, which would allow such a system to be put in place.

Also, it is noted above that the vertical communication of changes and goals has been insufficient. It has been noted in several studies that the implementation phase of changes is critical, and of central importance in implementation is communication of the change (Russ, 2008). Sufficient information can reduce resistance, improve willingness to implement change and enforce employee belief in management, specifically a failure to inform employees of what changes are necessary and why they are has a highly negative impact on the success of the change (Covin & Kilmann, 1990). In our study, doctors complain that communication has been lacking and in some cases inconsistent which has led to confusion and lack of engagement in work, employee discontent and, finally, resignations. In order to sustain successful relations with employees, clearer and more consistent communication is required (Palmer et.al., 2009).

Finally, the Lean production, or Lean Healthcare, framework has been described above. This was seen as a type of saviour for public healthcare, and much focus was put on it from managers. Both doctors and management still feel that this is one thing that could help solve many problems with organisation mentioned above. However, doctors have a feeling that Lean has fallen out of focus. Further work with streamlining processes to eliminate waste and increase efficiency is required.

VI - Conclusion

Our study focuses on the eye clinic in the context of an initial clinic-merger process between two hospitals (in 2008), PROLUMA, and the following merger between the entire hospitals (in 2010) to form SUS. Three years after the clinic-merger announcement a third of the doctors had resigned, mostly senior well-experienced doctors. Some left directly because of the merger, others indirectly and some without immediate relation to it. The merger and following competence loss had, according to the doctors, severe negative impact on the structure, competitiveness, efficiency and the provision of quality of care to the patients. The top managers explained that the problems mainly were caused by horizontal rivalry between the two clinics. The doctors were generally concerned with the purpose and manner of carrying out the merger. The different findings will be commented on separately below.

6.1 On the findings on how to measure efficiency

Quinn & Rohrbaugh (1981) argue that organisational efficiency is a value-based judgment about the performance of an organisation based on individual values, hierarchical position, type of unit, external or internal perspective, point in time, uncertainty in the environment, and numerous other factors. This study indicates that views on organisational and operational efficiency are different, or at least differently valued and prioritized, among groups on different vertical positions in a hospital.

From this follows that there are differing views on how to measure efficiency and carry out an organisational change where the end results are truly efficient. In our study we found different wills regarding the emphasis on either measuring economic efficiency or medical effectiveness which causes frustration among the doctors when economic incentives override their medical expertise. The reason to the priority disparity might be the different actors' educational and work backgrounds that influence how they act (L. Axelsson, Kullén Engström & Edgren, 2000).

6.2 On the findings on the purpose and results of the merger

All the participating doctors in this study verified that there had been rivalry between the two clinics prior to the merger. It seems to have been mainly a result of conflicts between certain individuals. Several doctors from both clinics indicated a lack of understanding for why that rivalry existed between those individuals and an ignorance of the actual reasons to its existence. Instead they claim that the rivalry was severely aggravated by how the clinic-merger was managed. This resulted in an "inflamed" and "war-like" process. However, in contradiction to the top management none of the doctors claimed that the negative consequences of the merger had much to do with the actual rivalry. Instead doctors from both clinics asserted that the problems existed due to the lack of understanding of what the actual purpose was and its legitimacy, how the merger was carried out and managed, and the inefficient final organizing of the merged clinic where the ward unit, on-call duty and existing networks suffered serious deterioration.

The existence of horizontally rivalry should not automatically be seen as the actual cause of a merger's failure since, as according to the Pygmalion effect of self-fulfilling prophecies: you are likely to find the kind of resistance you are looking for (Kanter et al., 1992) and you might even contribute to it (Ford, Ford & D'Amelio, 2008). Hence our study supports the findings of Choi (2011), studying another major Swedish hospital merger, that despite much organisational behaviour literature explaining merger failures with horizontally different cultures, the primary challenge for management at both hospital and clinical level is to deal with the vertical differences and the institutional competition between managerialism and professionalism.

The process and results of Proluma and the SUS merger indicate support to concerns voiced regarding the decision-makers convictions of hospital size as a determinant of performance, cost-efficiency and quality of care (Weil, 2010; Ahgren, 2008; Posnett, 2002). Change starts with initial failures to adapt (Weick & Quinn, 1999) but a fusion should not be seen as an easy-way out that quickly and automatically resolves the organisation's initially flawed business idea (Alarik, 1982). Instead this study proposes that the future direction of health care management should be to focus on the real issues within health care organisations and their operational processes. The importance of on-going training, personal and organisational networks, appropriate ancillary and support services as well as doctor's administrative work-load should not be overlooked (Weil, 2010; Posnett, 2002); especially since Swedish doctors are increasingly imposed to do more and more administrative work instead of treating patients (Svenér, 2010; Fölster et al., 2003; Hallin & Siverbo, 2003).

6.3 On the findings of managing the merger

Regarding how to carry out an organisational change where the end results are truly efficient, the top management is favouring a strictly top-down process, a strategy indicated to have several limitations (McNulty & Ferlie, 2004). Doctors and middle managers favour a bottom-up process where those who work close to the core operations are allowed to contribute to the actual design of their every-day work (Beer, Eisenstat & Spector, 1990). Considering the perceived results of the merger the same pattern exists. The Top Managers are happy with what they have achieved, though the focus of their evaluations is based primarily on the top of the organisational layers and not the operational core work. Middle managers are much more hesitant or slightly negative to the process and its outcomes while the doctors have not seen any improvement at all but an abundance of destroyed efficiencies and existing functions where structure has been replaced by chaos.

Hence the results of this study indicates that further attention need to be addressed to the involvement, contributions from and the operational and professional expertise of the doctors who are the ones actually treating the patient and have well-developed experience from what is efficient or not in their daily work. This is in accordance with the findings of (Elmqvist, 2002) who, in a comparison of seven other Swedish eye clinics, found that the operational managers had greater organisational skills than the top managers which resulted in a risk for tensions and conflicts.

6.4 On the views on efficiency

In this study the ones closest to the processes and the patient's have indicated that the efficiency problems are related to insufficient IT-systems, an inefficient job specialisation strategy and an undeveloped incentive and rewards structure. In accordance with other studies, these are some of the most important facets to consider in public healthcare (Elmqvist, 2002; L. Axelsson, 2000; Leopold & Harris, 2009). Furthermore, they indicate that a closely arranged network organisation aids communication and work environment, similar to that found by Hallin & Siverbo (2003), and that change programs should be more structured and well planned.

6.5 Final Comments

In conclusion, more precise goals on the operational level regarding organisation should be determined. These should address different needs within the organisation and thus be based on contingency factors for each specialty (Mintzberg, 1993). The burden of proof must be on those who propose the organisational changes to quantify the expected benefits and costs and to explain the process by which benefits will be realized in practice (Posnett, 2002; Canadian Health Services Research Foundation, 2004). In our study the top management proposing the mergers failed to provide satisfactory advantages to the employees who could neither understand nor accept the expected economic or qualitative improvements. Doctors should be allowed to influence and

contribute to the envisaged changes in order to fully exploit their operational and professional expertise. When the change actions, such as planning and implementing, are shared by the different actors involved in the change it can be carried out smoother and more efficiently, as the distinctions between the actors are less marked (Kanter et al., 1992).

To put this in relation to our initial purpose and objectives, we can conclude that:

1) There is little agreement as to how measurements in healthcare in general, and the SUS hospital in particular, should be defined. The differences can be summarised as management leaning towards financial measurements and volume of care, while doctors would like measurements to take into account the quality of care and service to patients.
2) There are different views on how to manage organisational change between managers and doctors. Management prefer a top-down approach where plans are carried out as stipulated and the results are dependent on how different employees engage with this process. Doctors believe that they should have more say in how the change is carried out, and that change should depend on the operational processes, and what is needed from a doctor-patient point of view.
3) From the context of the SUS merger it is clear that management has a narrow view of what doctor's feel is necessary for improving efficiency in their daily work. Doctor's stress the need for customized IT-support, stricter job specialisation, clear patient processes and the possibility to form informal networks and knowledge clusters. It appears that many of these efficiencies have been impaired as a result of the top-down managed merger.

It seems that our initial impression, that different views on efficiencies may cause problems in change processes, still poses a viable correlation between these aspects.

Finally, some call for more research regarding health care organizing and hospital mergers (e.g. Choi, 2011; Aiken & Sloan, 2002). We would like to add to this request. In his thesis on success factors in seven Swedish eye clinics Elmqvist (2002) concludes that there is a need for a new management style, professional involvement and a more holistic view on health care management. Our results are of the same character but in distinction to, or rather in addition to, calling for a more aggregated view we argue for an increased focus on the operational efficiencies instead of risking losing oneself up in the holistic clouds of top organisation panacea management, high above operational reality.

VII - References:

Abrahamson, E. (1996). Management Fashion. *Academy of Management Review 21(1)* , 254-285.

Abrahamson, E. (1991). Managerial Fads and Fashion: The Diffusion and Rejection of Innovations. *Academy of Management Review 16(3)* , 586-612.

Ahgren, B. (2007). Creating integrated health care. *The Nordic School of Public Health* , 174.

Ahgren, B. (2008). Is it better to be big? The reconfiguration of 21st century hospitals: Responses to a hospital merger in Sweden. *Health Policy 87* , 92-99.

Aiken, L., & Sloane, D. (2002). Hospital organization and culture. In M. McKee, & J. Healy, *Hospitals in a changing Europe* (pp. 265-278). Buckingham: Open University Press.

Al Mashari, M., & Zairi, M. (2000). Revisiting BPR: A holistic review of practice and development. *Business Process Management Journal, vol. 6, no1* , 10-42.

Alarik, B. (1982). *Fusioner - Drivkrafter, beslut och samordning.* Göteborg: Göteborgs universitet.

Alvesson, M. (2004). *Knowledge work and knowledge-intensive firms.* Oxford: Oxford University Press.

Alvesson, M., & Sköldberg, K. (2009). *Reflexive Methodology : New Vistas for Qualitative Research.* London: SAGE Publications.

Amis, J., Slack, T., & Hinings, C. R. (2004). The Pace, Sequence, and Linearity of Radical Change. *The Academy of Management Journal, Vol. 47, No. 1* , 15-39.

Arah, O. A., Klazinga, N. S., Delnoij, D. M., Ten Asbroek, A. H., & Custers, T. (2003). Conceptual frameworks for health systems performance: a quest for effectiveness, quality, and improvement. *International Journal for Quality in Health Care, Vol. 15, Nr. 5* , 377–398.

Arbetsförmedlingen. (2010). *Generationsväxlingenpå arbetsmarknaden – i riket och i ett regionalt perspektiv*. Retrieved May 12, 2011, from www.amf.se: http://www.arbetsformedlingen.se/download/18.76f5f98912bedd96d0780002435/generationsvaxlingen_rapport.pdf

Axelsson, L. (2000). *Den svenska hälso- och sjukvårdens styrning och ledning – en delikat balansakt.* Göteborg, Sweden: Nordiska hälsovårdshögskolan.

Axelsson, L., & Kullén Engström, A. (2000). *The concept of effectiveness – a blind alley? A study of different interpretations in a Swedish country council.* Submitted after revision. Published (as Paper III) in Axelsson, L (2000).

Axelsson, L., Edgren, L., & Svensson, P. (1999). Autonomy in the policy process in Swedish hospitals - loyalty a key concept. *The Scandinavian Journal of Management, 9 September* .

Axelsson, L., Kullén Engström, A., & Edgren, L. (2000). Management versus symbolic leadership and hospitals in transition – a Swedish example. *Journal of Nursing Management 8* , 167-173.

Axelsson, R. (1998). *Hälso- och sjukvårdsadministration i organisationsteoretisk belysning.* Lund: Studentlitteratur.

Backman, J. (2008). *Rapporter och uppsatser.* Lund: Studentlitteratur.

Bazzoli, G., Dynan, L., Burns, L., & Yap, C. (2004). Two decades of organizational change in healthcare: What have we learned? *Medical Care Research and Review, 6* , 247-331.

Beer, M., Eisenstat, R. A., & Spector, B. (1990). Why Change Programs Don't Produce Change. *Harvard Business Review* , 158-166.

Bemelmans-Videc, M.-L., Lonsdale, J., & Perrin, B. (2007). *Making accountability work : dilemmas for evaluation and for audit.* New Brunswick: Transaction Publishers.

Bender, J., & van Veen, K. (2001). What's in a fashion? Interpretative viability and management fashions. *Organization 8/1* , 33-53.

Berry, J. (1980). Social and cultural change. In H. Triandis, & R. Brislin, *Handbook of cross-cultural psychology, vol: 5* (pp. 211-280). Boston: Allyn & Bacon.

Besanko, D., Dranove, D., Shanley, M., & Schaefer, S. (2010). *Economics of Strategy.* Hoboken, NJ: John Wiley & Sons.

Beyer, J. M. (1999). Taming and promoting charisma to change organizations. *The Leadership Quarterly Volume 10, Issue 2* , 307-330.

Bhal, K., Bhaskar, U., & Ratnam, V. (2009). Employee reactions to M&A: Role of LMX and leader communication. *Leadership & Organization Development Journal, vol: 30 iss: 7* , 604-624.

Björklund, M., & Paulsson, U. (2003). *Seminarieboken - att skriva, presentera och opponera.* Lund: Studentlitteratur.

Boeker, W. (1992). Power and Managerial Dismissal: Scapegoating at the Top. *Administrative Science Quarterly, Vol. 37, No. 3* , 400-421.

Bryman, A., & Bell, E. (2007). *Business research methods.* Oxford: Oxford University Press.

Camara, D. d., & Renjen, P. (2004). The secrets of successful mergers: dispatches from the front lines. *The journal of business strategy, Vol. 25, Iss. 3* , 10-14.

Canadian Health Services Research Foundation. (2004). Bigger is always better when it comes to hospital. *Journal of Health Services Research & Policy, Vol. 9, Iss. 1* , 59-60.

Choi, S. (2011). *Competing Logics in Hospital Mergers - The case of the Karolinska University Hospital.* Stockholm: Karolinska Institutet.

Covin, T. J., & Kilmann, R. H. (1990). Participant perceptions of positive and negative influences on large-scale change. *Group & Organization Studies, 15(2)* , 233–248.

Creswell, J. (2001). When a Merger Fails: Lessons From Sprint. *Fortune, Vol. 143, Iss. 9* , 185-186.

Davidson, H., Folcarelli, P., Crawford, S., Duprat, L. J., & Clifford, J. C. (1997). The Effects of Health Care Reforms on Job Satisfaction and Voluntary Turnover among Hospital-Based Nurses. *Medical Care, Vol. 35, No. 6* , 634-645.

Donabedian, A. (2003). *An Introduction to Quality Assurance in Health Care.* New York: Oxford University Press.

Dowling, B., & Richardson, R. (1997). Evaluating performance-related pay for managers in the National Health Service,. *The International Journal of Human Resource Management, Vol. 8, Iss. 3* , 348-366.

Drucker, P. F. (1974). *Management: Tasks, Responsibilities, Practicies.* London: Heinemann.

Edén Berggren, E., & Silfverschiöld, M. (2010). *SUS- En teoretisk analys av sammanslagningen mellan USiL-UMAS.* Lund: Ekonomihögskolan Lunds Universitet.

Elmqvist, F. (2002). *Framgångsfaktorer vid styrning och ledning av hälso- och sjukvård – Jämförelser mellan sju ögonkliniker med olika styrmodeller.* Stockholm: Företagsekonomiska institutionen vid Stockholms universitet.

Ford, J. D., Ford, L. W., & D'Amelio, A. (2008). Resistance to change: The rest of the story. *Academy of Management Review, Vol. 33, No. 2* , 362-377.

Freemantle, N. (2002). Optimizing clinical performance. In M. McKee, & J. Healy, *Hospitals in a changing Europe* (pp. 252-264). Buckingham: Open University Press.

Freidson, E. (1975). *Doctoring together: a study of professional social control.* New York: Elsevier.

Freidson, E. (1994). *Professionalism Reborn: Theory, Prophecy and Policy.* Cambridge: Polity Press.

Fulop, N., Protopsaltis, G., Hutchings, A., King, A., Allen, P., Normand, C., et al. (2002). Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis. *BMJ, 325* , 246-73.

Fulop, N., Protopsaltis, G., King, A., Allen, P., Hutchings, A., & Normand, C. (2005). Changing organisations: a study of the context and processes of mergers of healthcare providers in England. *Social Science & Medicine, 60* , 119-130.

Fölster, S., Hallström, O., Morin, A., & Renstig, M. (2003). *Den sjuka vården: en granskning av hur sjukvårdens resurser används.* Stockholm: Ekerlids förlag AB.

Glebbeek, A. C., & Bax, E. H. (2004). Is High Employee Turnover Really Harmful? An Empirical Test Using Company Records. *The Academy of Management Journal, Vol. 47, No. 2* , 277-286.

Government Offices of Sweden. (2011, January 27). *Kömiljarden*. Retrieved May 13, 2011, from www.sweden.gov.se: http://www.sweden.gov.se/sb/d/11870

Hallin, B., & Siverbo, S. (2003). *Styrning och organisering inom hälso- och sjukvård.* Lund: Studentlitteratur.

Hamel, G., & Prahalad, C. K. (1994). Competing for the future. *Harvard University Press* , 122-128.

Harris, J., Ozgen, H., & Ozcan, Y. (2000). Do Mergers Enhance the Performance of Hospital Efficiency? *The Journal of the Operational Research Society, Vol. 51, No. 7* , 801-811.

Haspeslagh, P., & Jemison, D. (1991). *Managing acquisitions: Creating value through corporate renewal.* New York: The Free Press.

Jordan, M., & Stuart, N. (2000). Lessons learned. *CMA Management, Vol. 74, Issue 3* , 35.

Kanter, R. M., Stein, B. A., & Jick, T. D. (1992). *The Challenge of Organizational Change.* New York: The Free Press.

Kodner, D. L., & Spreeuwenberg, C. (2002). Integrated care: meaning, logic, applications, and implications – a discussion paper. *International Journal of Integrated Care – Vol. 2* .

Leopold, J., & Harris, L. (2009). *The strategic managing of human resources.* Harlow England: Prentice Hall/Pearson Education.

Locke, E., & Latham, G. (2004). What should we do about motivation theory? Six recommendations for the twenty-first century. *Academy of Management Review, vol: 29 iss: 3* , 388.

Locke, E., & Latham, G. (2004). What should we do about motivation theory? Six recommendations for the twenty-first century. *Academy of Management Review, vol: 29 iss: 3* , 388.

Malmström, & Orre. (2010). *How a merger in operational stage affects.* Uppsala: Bachelor Thesis, Department of Business Studies, Uppsala University.

McGuffog, & Wadsley. (1999). The general principles of value chain management. *Supply Chain Management: An International Journal, Vol. 4, Number 5* , 218-225.

McNulty, T., & Ferlie, E. (2004). Process Transformation: Limitations to RadicalOrganizational Change within Public ServiceOrganizations. *Organization Studies, 25(8)* , 1389-1412.

Mintzberg, H. (1993). *Structures in Fives: Designing effective organizations.* Upper Saddle River, New York: Prentice Hall.

Morris, P. (2008). *Disgruntled Employee: Manage Challenging Staff Without Losing Your Mind.* Avon, MA: Adams Media.

Morris, S., Devlin, N., & Parkin, D. (Chichester). *Economic Analysis in Health Care.* 2007: John Wiley & Sons.

Myrdal, G. (1969). *Objectivity in Social Research.* New York: Pantheon Books.

Nilsson, V. (1999). *Empati och distans - En studie av överläkare förhållande till ekonomistyrning.* Förvaltningshögskolan, Göteborgs universitet.

Norstedts engelsk-svenska ordbok. (1994). Second edition, third print: Norstedts förlag AB.

OECD. (2003, November 20). *Speech by Mme Berglind Ásgeirsdóttir*. Retrieved May 12, 2011, from www.oecd.org: http://www.oecd.org/dataoecd/57/17/23435997.pdf

Olafsson, G. A. (2008). Merging Hospitals: Motives, methods and outcomes. *Nordic School of Public Management* .

Olsson, B. (2005, August 17). När blir "sunt förnuft" modeord på sjukvårdens ledarskapskurser? *Dagens Medicin, nr 33* .

Palmer, I., Dunford, R., & Akin, G. (2009). *Managing organizational change : a multiple perspectives approach.* New York: McGraw-Hill Higher Education.

Pearson, A., O'Brien Pallas, L., Thomson, D., Doucette, E., Tucker, D., Wiechula, R., et al. (2006). Systematic review of evidence on the impact of nursing workload and staffing on establishing healthy work environments. *International Journal of Evidence-Based Healthcare* , 337-384.

Pierce, J. L., Kostova, T., & Dirks, K. T. (2001). Toward a Theory of Psychological Ownership in Organizations. *The Academy of Management Review, Vol. 26, No. 2* , 298-310.

Porter, M. E. (1985). *Competitive Advantage: Creating and Sustaining Superior Performance.* New York: The Free Press.

Posnett, J. (2002). Are bigger hospitals better? In M. McKee, & J. Healy, *Hospitals in a changing Europe* (pp. 100-118). Buckingham: Open University Press.

Proudlove, N., Moxham, C., & Boaden, R. (2008). Lessons from Lean in Healthcare from using Six Sigma in the NHS. *Public Money & Management, Vol. 28, iss 8* , 27-34.

Quinn, R. E., & Rohrbaugh, J. (1981). A Competing Values Approach to Organizational Effectiveness. *Public Productivity Review, Vol. 5, No. 2, A Symposium on the Competing Values* , 122-140.

Raman, S. (1998). Lean Software Development: Is it feasible? *Digital Avionics Systems Conference, vol1* , 1-8.

Redfern, S., & Christian, S. (2003). Achieving change in health care practice. *Journal of Evaluation in Clinical Practice, 9, 2* , 225–238.

Region Skåne. (2008a, March 14). *Alternativt förslag till samordning av ögonsjukvården i Lund och Malmö*. Retrieved May 7, 2011, from www.skane.se: http://www.skane.se/upload/Webbplatser/Proluma/Korrespondens/2008-03-14AndersBersstromAltforslagsamordnogonsjukvardenLundMalmo.pdf

Region Skåne. (2008b, February 17). *Angående flyttning av Lunds ögonklinik till Malmö*. Retrieved May 7, 2011, from www.skane.se: http://www.skane.se/upload/Webbplatser/Proluma/Korrespondens/2008-02-18AnitaBlixtOgonBlekinge.pdf

Region Skåne. (2008h, March 10). *Angående samordningen av ögonsjukvården USiL-UMAS*. Retrieved May 13, 2011, from www.skane.se: http://www.skane.se/upload/Webbplatser/Proluma/Korrespondens/2008-03-11BrevSorenOlofssonfrAndersBergstrom.pdf

Region Skåne. (2008c, March 28). *Grunddokument för förnyelsearbetet*. Retrieved May 3, 2011, from www.skane.se/proluma: http://www.skane.se/upload/Webbplatser%20Internt/F%C3%B6rnyelsearbetet/Grunddokument%20F%C3%B6rnyelse%201.1.pdf

Region Skåne. (2011, February 22). *Om Skånes universitetssjukhus*. Retrieved May 3, 2011, from www.skane.se: http://skane.se/templates/Page.aspx?id=293722

Region Skåne. (2009a, February 24). *Proluma Ögon Delrapport Lösningsfasen*. Retrieved May 3, 2011, from www.skane.se/proluma: http://www.skane.se/Public/Proluma/Dokument/Samordningsgrupp/Delrapport/ogonDelrapp09feb.pdf

Region Skåne. (2010a). *Skånes universitetssjukhus - Avancerad sjukvård - Utbildning - Framstående forskning*. Retrieved May 12, 2011, from www.skane.se: http://skane.se/Public/SUS_extern/Dokument/Om%20SUS/sus_fusionsbroschyr100531.pdf

Region Skåne. (2009h, December 15). *Ständigt bättre vård*. Retrieved May 13, 2011, from www.skane.se: http://www.skane.se/templates/Page.aspx?id=276862

Region Skåne. (2009b, May 26). *Svar angående Bedömning av retinaforsknings eventuella, aktuella och framtida behov av slutenvårdsplatser vid USiL*. Retrieved May 3, 2011, from www.skane.se/proluma: http://www.skane.se/Public/Proluma/Dokument/Ogon/2009-05-26UtrednretinaforsknVplUSiL.pdf

Region Skåne. (2008d, February 29). *Synpunkter på den pågående processen kring profilering och samordning mellan Ögonklinikerna vid Universitetssjukhuset MAS (UMAS) i Malmö och Universitetssjukhuset i Lund (USiL) och kommentarer på dessa*. Retrieved May 7, 2011, from www.skane.se: http://www.skane.se/upload/Webbplatser/Proluma/Korrespondens/2008-03-05%20UMAS%20-%20Synpunkter%20p%C3%A5%20processen.pdf

Region Skåne. (2010b, March 12). *Uppdrag: Skånes universitetssjukhus fusionsprocess*. Retrieved May 13, 2011, from www.skane.se: http://www.skane.se/Public/SUS_extern/Dokument/Om%20SUS/om%20oss/Projektuppdrag_SUS%20fusionsprocess100312.pdf

Region Skåne. (2008e, March 19). *Uppdragsbeskrivning projektledare PROLUMA*. Retrieved May 3, 2011, from www.skane.se/proluma: http://www.skane.se/upload/Webbplatser/Proluma/Dok%20Uppdrag/Uppdrag_ProjLed_080319_PROLUMA.pdf

Region Skåne. (2009c, January 27). *Utredning retinalkirurgi - BJ*. Retrieved May 3, 2011, from www.skane.se/proluma: http://www.skane.se/Public/Proluma/Dokument/Ogon/2009-01-27_PROLUMA_%C3%96gon_Bengt_Jeppsson_utredning_retinakirurgi.pdf

Region Skåne. (2009d, January 27). *Utredning retinalkirurgi - KO*. Retrieved May 3, 2011, from www.skane.se/proluma: http://www.skane.se/Public/Proluma/Dokument/Ogon/2009-01-27_%C3%96gon%20PROLUMA-Karl_Obrants_utredning_retinakirurgi.pdf

Region Skåne. (2009e, January 28). *Utredning retinalkirurgi - Resultat*. Retrieved May 5, 2011, from www.skane.se/proluma: http://www.skane.se/Public/Proluma/Dokument/Ogon/2009-01-28_PROLUMA_Utredning_retinakirurgi_UMAS-USiL.pdf

Region Skåne. (2009f). *Verksamhetsplan & Budget 2009*. Retrieved May 12, 2011, from www.skane.se: http://www.skane.se/upload/Webbplatser/UMAS/VERKSAMHETER%20UMAS/Ledningsorganisationen/Kommunikationsavdelningen/Dokument/Hamta%20o%20Bestall/Trycksaker/UMAS_Verksamhetsplan_2009.pdf

Region Skåne. (2009g, March 27). *www.skane.se*. Retrieved May 12, 2011, from Beslutsförslag PROLUMA lösningsfas Omgång 1 A-B: http://skane.se/Public/Proluma/Dokument/Styrgrupp/2009-03-27%20Beslutsf%C3%B6rslag%20PROLUMA%20l%C3%B6sningsfas%20Omg%C3%A5ng%201%20-%20slutversion.pdf

Region Skåne. (2007, February 13). *ÅRSREDOVISNING 2006 för Universitetssjukhuset i Lund*. Retrieved May 12, 2011, from www.skane.se: http://www.skane.se/upload/Webbplatser/USiL/Dokument/InfoOmOss/arsredovisning_2006.pdf

Region Skåne. (2008f, January 28). *Ögonsjukvården i Lund och Malmö*. Retrieved May 3, 2011, from www.skane.se: http://www.skane.se/upload/Webbplatser/Proluma/Korrespondens/2008-02-18OgonklinUSiLAndersBergstrom.pdf

Rosengren, K., Kullén Engström, A., & Axelsson, L. (1999). The staff's experience of structural changes in the health and medical service in western Sweden. *Journal of Nursing Management, 7* , 289-298.

Russ, T. L. (2008). Communicating Change: A Review and Critical Analysis of Programmatic and Participatory Implementation Approaches,. *Journal of Change Management, Vol. 8, Iss. 3-4* , 199-211.

Schweiger, D. M., & DeNisi, A. S. (1991). Communication with Employees following a Merger: A Longitudinal Field Experiment. *The Academy of Management Journal, Vol. 34, No. 1* , 110-135.

Skånska Dagbladet. (2011a, March 19). *Patient flögs till Örebro*. Retrieved May 6, 2011b, from www.skanskan.se: http://www.skanskan.se/article/20110319/MALMO/703189682/1162/TTEKONOMI/-/patient-flogs-till-orebro

Skånska dagbladet. (2011b, March 21). *Ögonkliniken brottas med långa köer*. Retrieved May 12, 2011, from www.skanskan.se: http://www.skanskan.se/article/20110321/MALMO/110329973/1004

SOU, 1995:5. (1995). *Prioriteringsutredningen. Vårdens svåra val.* Stockholm: Socialdepartementet.

Staw, B. M. (1980). The Consequences of Turnover. *Journal of Occupational Behaviour, Vol. 1, No. 4* , 253-273.

Svenér, M. (2010). *När överläkaren berättar : om roller och drivkrafter i en profession i förändring.* Lund: Institutet för ekonomisk forskning, Lunds universitet.

Sydsvenskan. (2010, October 7). *Beslut om Sus ska tas om*. Retrieved May 12, 2011, from www.sydsvenskan.se: http://www.sydsvenskan.se/lund/article1259557/Skanskt-sjukhusbeslut-upphavs.html

Taylor, S., & Bogdan, R. (1998). *Introduction to qualitative research methods : a guidebook and resource.* New York: Wiley.

Thompson, A. A., Strickland, A. J., & Gamble, J. E. (2007). *Crafting and Executing Strategy.* New York: McGraw-Hill/Irwin.

Ton, Z., & Huckman, R. S. (2008). Managing the Impact of Employee Turnover on Performance: The Role of Process Conformance. *Organization Science, Vol. 19, No. 1* , 56-68.

Trautwein, F. (1990). Merger motives and merger prescriptions. *Strategic Management Journal, 11* , 283-295.

Tremblay, M., Blanchard, C., Taylor, S., Pelletier, L., & Villeneuve, M. (2009). Work Extrinsic and Intrinsic Motivation Scale: Its Value for Organizational Psychology Research. *Canadian Journal of Behavioral Science, vol: 41 iss: 4* , 213.

Tremblay, M., Blanchard, M., Taylor, S., Pelletier, L., & Villeneuve, M. (2009). Work Extrinsic and Intrinsic Motivation Scale: Its Value for Organizational Psychology Research. *Canadian Journal of Behavioral Science, vol. 41, iss. 4* , 213.

Ulrich, D. (1997). A new mandate for human resources. *Harvard Business Review, 76(1)* , 124-134.

Wallenberg, J. (1997). *Kommunalt arbetsliv i omvandling : styrning och självständighet i postindustriell tjänsteproduktion.* Stockholm: SNS Förlag.

Walston, S. L., Burns, R. L., & Kimberly, J. R. (2000). Does Reengineering Really Work? An Examination of the Context and Outcomes of Hospital Reengineering Initiatives. *Health Services Research, Vol. 34, Iss. 6* , 1363-1388.

Weick, K. E., & Quinn, R. E. (1999). Organizational change and development. *Annual review of psychology, Vol. 50, Iss. 1* , 361-386.

Weil, T. (2010). Hospital mergers: a panacea? *Journal of Health Services Research & Policy Vol 15 No 4* , 251–253.

Womack, J., Jones, D., & Ross, D. (1990). *The Machine That Changed the World.* New York: Rawson Associates.

Appendix I

Interview format and questions

Introducerande frågor

1. Skulle du kort kunna sammanfatta din yrkesmässiga bakgrund (utbildning, karriärsteg)?
2. Vad är dina dagliga sysslor just nu?
3. Hur kom du in i processen för sammanslagningen?

Strategiskt syfte med sammanslagningen

1. Vad var syftet med sammanslagningen?
2. Fanns det några fler sekundära orsaker?
3. Hur väl har ni uppnått målen med sammanslagningen? Vad är resultatet hitintills?
    a. Har sammanslagningen fått negativa konsekvenser?
    b. Var man beredd på att negativa konsekvenser skulle uppstå? Hur förberedde man sig?
    c. Använda man sig av teorier, exempel och inspiration från litteratur och andra sjukhussammanslagningar? Vilka?

Strategisk effektivitet

1. Vad finns det för fördelar med att slå ihop specialistkliniker från Malmö och Lund?
2. Vad finns det för fördelar med att istället ha kvar specialistkliniker både i Malmö och i Lund?
3. Vid tal om sammanslagningar och effektivitet så nämns ofta synergieffekter/skalfördelar som ett önskvärt resultat. Men mer specifikt sett, vad räknade man med att dessa synergieffekter skulle bestå av? (T.ex. spara in på personal, lokaler, material etc.)

Operativ effektivitet – läkarnas dagliga arbete

1. Vad är effektivitet i en läkares dagliga jobb?
2. Hur kan denna effektivitet mätas?
3. Hur kan denna effektivitet förbättras?

- (Till ledningen): Hur anser du att läkarna ser på effektivitet?
- (Till läkare): Hur anser du att ledningen ser på effektivitet?

Bakgrundsfrågor/Funderingar – Inte ordinarie: ställs bara i mån av tid

1. Hur tänker du dig att resultatet av sammanslagningen kommer vara om 10 år?
2. Var det hos specialisterna man såg de stora förbättringsmöjligheterna?
    a. Varför valde man en sammanslagning istället för ett strategiskt samarbete mellan två fristående sjukhus?
    b. Varför slå ihop hela sjukhusen och inte bara de 8 % som utgör specialister?
3. Om du var ensamt ansvarig för att ansvara över sjukhusets effektivitet och fick välja mellan ett och fem effektivitetsmått. Vilka skulle du välja och hur skulle du prioritera dem?
4. Vilka, inom kanske andra sjukhus, ofta använda eller ibland diskuterade effektivitetsmått tycker du är direkt eller indirekt olämpliga att använda inom hälso- och sjukvård?

- (Till ledningen): Hur påverkar läkarnas handlingar och beslut den strategiska effektiviteten?
- (Till läkare): Hur påverkar ledningens handlingar och beslut den operationella effektiviteten?

Specialfrågor till läkare:

- Finns det någon oro över att självständigheten som läkare minskar?
- Finns det någon oro över att det kan ske en förskjutning av makt/inflytande i organisationen?
- Finns det någon risk för att förlora värdefulla ”professionsegenskaper?”
- Det hävdas att sammanslagningen leder till att beslut decentraliseras. Kommentarer?
- Vad anses om schemaläggning och forskningstid. Det börjar ju ändras nu. Kommentarer?
- När en läkare utses till chef – brukar den personen på något sätt genomgå en förändring?