

Merging Hospitals: Motives, methods and outcomes

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This thesis reviewed recent hospital mergers in Gothenburg, Sweden, and Reykjavik, Iceland, and describes, analyzes, compares, and assesses those mergers. The study focused on the underlying reasons for the mergers, examining both the methods used in the merging process and the merger outcomes. Background information includes organizational theory regarding mergers, hospitals as professional bureaucracies, organizational change and communication, and quality and efficiency in organizations. The study is based on secondary data derived mainly from official documents, evaluations, and research reports. While the study determined similar reasons—mainly economic—underpinning both mergers, the processes differed. The Swedish merger was much better prepared, more radical, and invested more time and money in its process compared to the Icelandic merger, which was less radical and characterized by decisions from the top. Interestingly, the Icelandic merger, which sought to curtail the growth of expenditures but did not demand savings, achieved outcomes that reflected its main goals. Conversely, the Swedish merger sought unrealistic savings in its goals and the savings demands made it impossible for the management team to gain other objectives of the merger, like better service, quality and more competent institution.

Key words

mergers, hospitals, organization, efficiency, quality

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Foreword

In recent decades, there has been a trend for modernizing the public sector by implementing management strategies from the private sector into the public sector. One of these strategies is the merging of organizations. Before I started this study, I saw only positive possibilities regarding the merger of organizations, especially public organizations. Since most public organizations are funded by the taxpayers, all measures to make such organizations more effective should be welcomed. However, things are more complicated than they appear to be. This study shows that merging public organizations is a very delicate matter.

I would like to acknowledge the assistance of the following people during the development of this study: My supervisor, Runo Axelsson, has my deepest thanks for his advice, support and recommendations. The Director of Landspítali-Háskólasjúkrahús, Magnús Pétursson, and the Director of Research at Sahlgrenska University Hospital, Ingvar Svensson, have my thanks for their help with finding references for the mergers. I would also like to thank Ásta Arnarsdóttir, Birgir Gunnarsson, Daníel Svavarsson, Elvar Örn Arason, Ingimar Einarsson, Jóhanna Ýr Jónsdóttir, Ólafur Ólafsson and many others for their support and for reading the manuscript. However, in the end, all responsibility rests on the author's shoulders.

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1. Introduction

“The modern hospital is the same organization as it has been since hospitals were founded, a service organization whose primary task is to give medical service for those who need it.”
(Hallin, 2002)

In the past two decades, the health care systems in the majority of the Western world have undergone nearly continuous changes. There have been both major structural changes and institutional changes, in an attempt to increase efficiency and to control health care expenditure. The rising costs of health care have been the driving force of these changes. The costs of health care have increased because of new technology, more demand for better quality and services and an ageing population. The health care costs have therefore been taking a larger share of GDP (Gross Domestic Product) in most Western countries. The increasing costs have put health care higher on the political agenda. Among many politicians, there is now a will to halt the expansion of health care and a “wishful thinking” to decrease the cost of health care (Sigurgeirsdóttir, 2005).

One of the strategies used to decrease health care costs has been to merge hospitals. This study will describe two separate mergers of hospitals that occurred in Gothenburg, Sweden, and in Reykjavik, Iceland. There are several reasons for selecting these two mergers for study. First, the author has lived in both cities and followed the process of merging the hospitals.. Secondly, the mergers took place at a similar time. Thirdly, the hospitals studied are parts of similar Nordic health care systems.

Both the Swedish and the Icelandic health care systems are public systems, which mean that health care is financed mainly by taxes and provided mainly by public providers. There are some differences, however, between the Swedish and the Icelandic systems.

The Swedish healthcare system is decentralized. Previously, the state was responsible for a large part of the health service, except for the somatic hospitals that belonged to the county councils. In the 1960s, the government decentralized the responsibility for primary health care and psychiatric care from the state to the county councils (Svenska

kommuner och landsting, 2005). Now the county councils together with the municipalities are responsible for providing, financing and managing the health services within their geographical areas. The Ministry of Social Affairs and the National Board of Health and Welfare (*Socialstyrelsen*), is responsible for supervision of the quality of the services. According to the Swedish *Health Care Law* (1982:763), the county councils are responsible for offering their inhabitants “a good and equal healthcare” (<http://www.notisum.se/rnp/SLS/LAG/>).

In the Icelandic health care system the role of the state is much greater than in Sweden and the other Nordic countries. According to the *Health Care Act* (Lög um heilbrigðisþjónustu, 1990) and the law regarding the division of tasks between the state and municipalities (Lög um breytingu á verkaskiptingu ríkis og sveitarfélaga, 1989) the state is responsible for financing, delivering and regulating health care. The Ministry of Health and Social Security is ensuring that the health care laws are followed, and it is also the main health care administrator. The ministry is dealing with formulation of health policies and implementation of those policies (Sigurgeirsdóttir, 2005). It has, for the last decade, tried to strengthen its central role at the expense of a previous decentralization, which was the policy of the *Primary Health Act* in 1974. The merger of two hospitals in Reykjavik in 1999 is a part of this policy of centralization (Halldórsson, 2003).

Against this background, the general aim of this study is to describe, analyze, compare and assess the mergers of the hospitals in Gothenburg and Reykjavík. Starting from this general aim, the study will more specifically focus on the following research questions:

- 1) What were the main reasons behind the two mergers?
- 2) What methods were used in the merging of the hospitals?
- 3) Were the mergers successful or not?

The study is structured in the following way: In the next section, some theories about mergers, efficiency, hospitals, organizational change and quality are introduced as a theoretical background. After that, in section three, the methodology of the study is de-

scribed. In section four, the two cases of merger are described, and in section five, the cases are analyzed and compared. In section six, there is a general discussion. In section seven, there is conclusion based on the description and analysis of the two hospital mergers studied.

2. Theoretical background

2.1. Mergers of organizations

A merger means that two or more organizational units are brought together into one unit. There are two types of mergers, horizontal and vertical. A *horizontal* merger brings together organizations that are at the same level of production or service provision, making selections of products or services. A *vertical* merger brings together different organizations that are vertically related in the production or service chain, for instance one organization producing inputs for another (Jacquemin, Buigues and Ilzkovitz, 1989).

One of the main reasons for merging organizations is the synergy effect, which is often explained by the formula $2+2=5$. This is related to another effect called the economies of scale. The essence of both of these effects is that two or more organizations may be run more efficiently together than apart, by combining skills and resources. Thus, the gain of a merger may be an improved efficiency by using the existing resources in a better way and allowing more specialization inside the organization (Nupponen, 1995). Efficiency can be defined as the extent to which goals are met by the use of a given set of resources. Organizations can thus be said to be efficient if they use no more resources to produce a commodity or service than is necessary (Jacobsen & Thorsvik, 1995).

Another reason for merging organizations is that the combination of skills and resources from two or more organizations may improve the quality of the production or service provision. For organizations that provide care, for example hospitals, an important reason for mergers is to improve the quality of care (Hallin, 2002).

A merger of organizations can fail due to various reasons. According to Alarkin, there are three key factors that may explain failures in connection with a merger (Alarkin, 1982):

1. The goals of the merger are not clear.
2. The negotiations of the merger are not done in a proper manner.

3. The planning and coordination in the new organization is done in an ineffective way.

In addition to these factors, differences in organizational cultures may be problematic in a merger of organizations. Problems can arise because the cultures of the organizations that are merged are so different that it is difficult for them to understand and adjust to each other (Ohlsson, 2001).

Another problem in merging organizations is that the expectations regarding the outcome of the merger may be too high. Expectations of an increased production or an improved quality may lead to dissatisfaction when the results are not according to the expectations (Nupponen, 1995). Such expectations may be one of the biggest problems in connection with a merger.

A successful merger has clear goals about what the merger is supposed to gain (Alarkin, 1982). Nupponen argues that in successful mergers the general managers are appointed early in the process, and the communication channels in the new organization are well known by all personnel. Communication plays a vital role, because it helps the personnel to understand the reasons and the goal for the merger, and reduces uncertainty for them. If the personnel do not have a clear reporting relationship to the management, and if the organization has a poor communication system, then the new organization may have problems (Nupponen, 1995).

2.2. Bureaucracy and hospitals

When organizations become bigger, it becomes more difficult to administrate them. One of the most common structures for the administration of large organizations is the *bureaucratic* structure. The main factors that make bureaucracy work are specialization, standardization and co-ordination. In this way, the bureaucratic structure can be very efficient to achieve economies of scale and to avoid duplications. The bureaucratic structure works best when there are clear rules of co-ordination and a clear chain of command (Ballé, 1999). Hospitals are examples of a special kind of bureaucratic organizations called professional bureaucracies. Such an organization employs trained and

skilful professionals, who perform the main work in the organization and have a considerable control and autonomy over their work (Mintzberg, 1983). At the same time, such organizations also live up to the bureaucratic ideal: they provide services on a large scale and operate according to rules, routines and guidelines, which have been developed over a long time. Thus, professional bureaucracies like hospitals are at the same time professional organizations and administrative bureaucracies.

Hospitals in countries with a public health care system are not only professional and bureaucratic, they are also political organizations. They have been described as consisting of three different “domains”. These are the domains of *politics* (politicians), *administration* (management) and *service* (professionals). Each has its own principles and guidelines on how to do things. This is also a ground for conflicts between the three domains. Sometimes two of the domains side together against the third, such as the politicians and the administrators against the professionals. The politicians, who often see themselves as owners of the hospitals, expect the administrators to implement their decisions, for example keeping the budget in balance. Simultaneously, the professionals demand the best conditions to carry out their work, which can be in conflict with given financial resources. How the resources are divided between the domains and how this is decided is a result of further struggle for power between the three domains (Kouzes & Mico, 1997).

New Public Management is a new approach to management in the public sector. Management tools from the private sector are used in public organizations in order to improve the efficiency of the public sector. The assumption is that the private sector is more efficient than the public sector. New Public Management can be everything from contracting, internal competition or performance based financing. It was supposed to replace the traditional way how the public sector was financed through budgets and fixed funding. During the last years, however, New Public Management have been criticized for high administrative costs and this criticism has weakened the support for the models (Brorström, 2004).

2.3. Organizational change and communication

There are two main types of changes in an organization, evolutionary and revolutionary change. Evolutionary change occurs when changes are made incrementally through many small steps. A number of evolutionary changes can, in the end, add up to radical changes. These changes take place over a long period. Revolutionary change occurs when an organization undergoes radical change in short time. This means changes in the organization's goals and strategies. This is a dramatic change as the organization meets new and unknown challenges. The whole organization is affected by this change (Jacobsen et al., 1995).

When an organization plans a radical change, for example a merger, the reaction of the personnel is often characterized by distrust, stress, insecurity and lower morale. The personnel worry about their future, their careers, and their position in the new organization. The consequences of all this may lead to conflicts between managers and personnel. This can easily lead to reduced service of the organization and disable it (Nuppenen, 2005). When changes occur in organizations and are met by opposition among the personnel, the management must therefore "sell" the new solution to the personnel, and persuade the personnel to accept the changes (Alarkin, 1982).

Changes in an organization can also be stressful for the personnel due to economic reasons. A priority to balance the budget in the organization may change the thinking of the personnel. The personnel become more stressed, and their working enjoyment is reduced. The personnel are afraid that if a budget deficit occurs at the end of the year, the organization will go through further changes, first on a managerial level and then, if the budget deficit continues, structural changes will follow (Brorström & Hallin, 2002).

There are special difficulties in changing a professional bureaucracy. Professionals, physicians, nurses, and teachers have difficulties in accepting decisions taken by others regarding their working conditions. The professionals have their own working practices, demands for quality and ethical rules. Their loyalty towards their employer is less than their loyalty towards their own colleagues (Borgert, 1992). When the politicians or the

administrators demand more efficiency and economy in the organization, the professional autonomy, the ethical principles and the professional relationships inside the organization are in danger (Brorström et. al., 2002). This is one example of conflicts between the three domains mentioned earlier.

Communication is an important part of managing, controlling and co-ordinating an organization. Management builds on existing information of what is going on in an organization. This kind of information can only be available if the communication in the organization is adequate. Efficiency in an organization is dependent on a good communication system. Such a system is also vital for the organizational culture, which can have a positive and productive effect on an organization. The personnel in an organization with a positive culture have trust in each other. This trust can lead to better communication between members of an organization, which in turn can increase the trust (Jacobsen et. al., Thorsvik 1995).

2.4. Quality and efficiency

Efficiency has been defined as the extent to which goals are met by the use of a given set of resources, which means that organizations are efficient if they use no more resources to produce a commodity or service than is necessary (Jacobsen et. al., Thorsvik 1995). Effectiveness is a broader concept including also considerations of quality. Organizational effectiveness can be defined as the degree to which the goals of an organization are successfully met within a given standard of quality, which means that organizations are effective if they fulfill their goals not only in an efficient way but also with an acceptable quality (Shortell and Kaluzny, 2000).

Quality is important for all kinds of organizations, but particularly important for organizations dealing with human services, for example health care. It is a very difficult concept that is often defined as the extent to which the needs of the customers or clients are being satisfied. Quality management is the constant improvement of quality. This means to design simple and efficient ways to meet the needs of the customers or clients. It also means to take care of delays, waste and errors in the production or service. In this way,

quality management may at the same time decrease costs, increase efficiency and improve customer or client satisfaction (Øvretveit, 1992).

There are three main dimensions in health service quality:

- 1) Client quality: What the clients want from the service.
- 2) Professional quality: Professional quality standards to meet customer needs.
- 3) Management quality: Effective and productive use of existing resources. Goals are met with the lowest costs (Øvretveit, 1992).

It is commonly believed that improving the quality in a health organization will increase the costs. In fact, however, a higher quality often decreases the costs since it reduces waste, delays and errors. An increasing quality means not only increasing customer's or client's satisfaction with the product or service, it may also increase efficiency and reduce costs (Øvretveit, 1992).

2.5 Summary

Horizontal and vertical mergers are the main types of mergers. Organizations are often merged to get a synergy effect, where the new organization performs better than the merged organizations do when they are apart. The expectations of a positive outcome must be modest, however, because too high expectations can be damaging for the merger. Failure of merging organizations can occur when the goals of the merger are not clear. Lack of proper cooperation, poor communication systems, lack of resources and problems to adjust different cultures in the new organization are well-known difficulties of organizations that merge. On the other hand, clear goals, good communication systems and a proper administration of the merging process, may contribute to a successful merger.

Hospitals are large professional organizations and a bureaucratic structure is often used to administrate the hospitals. However, in such a professional bureaucracy, the hierarchy of the bureaucratic model can lead to conflicts between professionals and adminis-

trators as well as politicians in public health care systems. To meet the increasing cost of the public sector, including the health care system, a new approach, *New Public Management*, has been introduced in many countries. This approach means that management methods are adopted from the private sector.

Changes of organizations can be revolutionary or evolutionary. It is difficult to change a professional organization and radical changes, like mergers, can disturb the professionals and their loyalty to the organization. When organizations are changed because of economic reasons or pressure, this can lead to a stressful and difficult working atmosphere in professional organizations, and it can also lead to conflicts between professionals, administrators and politicians.

Quality is essential for all organizations, but particularly for organizations dealing with human services. Quality and efficiency may be difficult to combine, but not necessarily. High quality increases the organizations' reputation and the customers' or clients' satisfaction with the products or services, but it may also lower the organizations' costs and improve their efficiency.

3. The study methodology

As outlined in the introduction chapter, the main purpose of this study is to describe, analyze, assess and compare the merging of hospitals in Gothenburg and Reykjavik. The study is limited to the preparations for these mergers, their implementation and the first three operational years of the new merged hospitals.

3.1. The data and the data collection

The description of the two mergers is based on secondary data, which means data that have been collected by others and for other purposes. A search for relevant data in reports, evaluations and other official documents has been performed. Due to the nature of the phenomena studied, the scientific databases have been of limited value. Instead, the data has been retrieved from official archives, newspapers, unpublished research reports and the Internet.

Formal as well as informal sources have been used to locate relevant data about the mergers. Archival records were used as formal sources, both in Gothenburg and Reykjavik, to locate official documents related to the mergers. These documents included minutes from meetings, political and management decisions in connection with the mergers, and information to the personnel of the hospitals involved. A doctoral thesis about the merger in Gothenburg (Hallin, 2002) was also used both as a source of information and a source of further references, for example unpublished research reports from different departments of the university. There were also some informal sources of information deriving from personal contacts. For example, the author met and interviewed the director of research at the Sahlgrenska University hospital, Mr. Ingvar Svensson, who gave valuable recommendations of sources to use in the study.

It was more difficult to locate sources for the merger in Reykjavik than in Gothenburg. This is consistent with the opinion of Sigurgeirsdóttir, who claims that there is insufficient literature available on health care reform or health care evaluations in Iceland

(Sigurgeirsdóttir, 2005). However, an interview with Mr. Magnús Pétursson, the director of the Landspítali-Háskólasjúkrahús, gave the author valuable tips of sources for the Icelandic case and from these sources it was possible to find other relevant sources for the study.

The method used in the search for relevant data can be described as a detective method, where one source led to another until the phenomena were illuminated in a satisfactory way. The accuracy of the data were critically assessed in the way that historians are working (Frankfort-Nachmias, 1996), but there were very few contradictions of facts in the material collected. However, the content of the data differed between the two mergers. The Swedish data focused more on the merging process, the implementation of the merger and the outcome of the merger, and less on the economic factors. The Icelandic data focused much more on the economic factors, both before and after the merger.

Although there were more data about the Swedish merger and the two sets of data had a different emphasis, the description of the mergers has been structured in a similar way to facilitate a comparison between the two mergers. There is first some general information about the hospitals involved. Then the merger is described in three parts: the merging process begins, the merger, and after the merger.

3.2. The analysis and assessment

The analysis of the data was performed through a systematic comparison of the mergers in Gothenburg and Reykjavik, focusing on the reasons behind the mergers, the methods used in merging the hospitals, and the outcomes of the mergers. The analysis of the outcomes is an attempt to assess, in general terms, whether the mergers were successful or not.

An assessment of the outcomes means a crude evaluation of the results of the mergers. Evaluations can be retrospective, prospective or ongoing. In prospective and ongoing evaluations there are possibilities to design the evaluation in accordance to the changes

which are planned and decide what data to examine and not. This is more problematic in retrospective evaluation like this, where the evaluator is dependent on available secondary data (Øvretveit, 2001). A special problem with retrospective evaluations is when such an evaluation can be performed. It is very difficult to evaluate the results of the two mergers studied after such a short time. There is an obvious risk that only the merging process is evaluated, not the long term results.

Another problem with retrospective evaluations is that the goals against which the results shall be evaluated may not be measurable. This is the case also with the two mergers studied. It is very difficult to evaluate the outcomes of the mergers, since some of the goals were not so clearly formulated and some of them were not so easy to measure, for example to increase the quality of care. In such a situation, there is always a risk that the evaluation becomes too much focused on the measurable goals, particularly on the economic consequences of the mergers.

3.3. Methodological limitations

There are some obvious limitations in using secondary data. There is a gap between primary data, which is collected with a specific research purpose, and the intention and purpose of others using the data. Another problem of using secondary data is insufficient information about how the data was collected, which could lead to potential bias, error or problems with internal or external validity (Frankfort-Nahcmias, 1996). Regarding the use of official documents, it is important to realize that many of them are socially produced materials reflecting biases in society. Therefore, it is important to be aware of whom they originally were written to or for, what sources were used, and the completeness of the documents or archives (Bowling, 2002).

The reason why secondary data instead of interviews was used in this study is the time constraints and the costs related to the geographical scope of the study. The option of supplementing the study and its documentary data with interviews was abandoned for the same reasons.

4. The two mergers

4.1. The Swedish merger

In this section the Swedish merger is described, starting with a general description of the institutions involved in the merger followed by a discussion on the preparations for the merger, then the merger process and finally the aftermath or outcome of the merger.

4.1.1. General information about the hospitals

The Sahlgrenska University Hospital (SU) was established in January 1997 by merging three hospitals in the Gothenburg area. The hospitals that were merged were the Sahlgrenska and the Östra hospitals, which were owned and operated by the City of Gothenburg, and the Mölndal hospital, which was owned and operated by the County Council of Bohuslän. SU was structured from the beginning with ten divisions, which had their own division managers. The merger created one of the largest hospitals in Northern Europe. The SU hospital is responsible for regional health and medical care in West Sweden, serving over 1.7 million inhabitants. The SU hospital has close connections with Gothenburg University, in educating health professionals. In SU, research is conducted and the personnel participate in this research. In 1997, the budget for SU was around six billion SEK, the number of personnel was 16,000 and the hospital had over 2,500 beds. The number of personnel made SU one of the biggest employers in West Sweden (Hallin 2002). The health sector takes 90% of the budget of the region and SU takes about 40% of the health sector budget (Brorström, 2004).

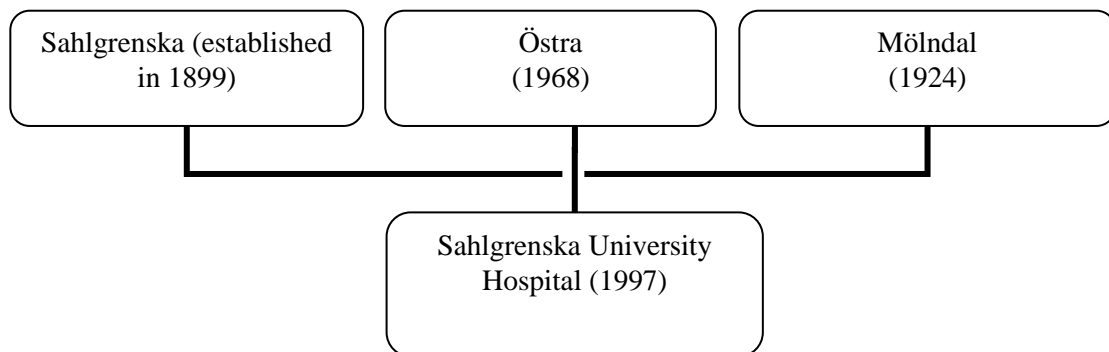


Figure 1. Merger of the Swedish hospitals.

The three hospitals in Gothenburg developed in different ways. The smallest hospital of the three, Mölndal, was a well functioning hospital with high quality of care, where the hospital's management team worked intensely with the personnel. The hospital had a performance-based financing system inspired by New Public Management. The second biggest hospital of the three was Östra. The hospital provided full medical service but focused on childcare. In its last years of operation, Östra also used a performance-based system to finance its operation. The largest hospital of the three was Sahlgrenska, which was the leading hospital in West Sweden and focused on high technical medical care, research and education of medical professionals. Sahlgrenska had also been financed based on performance (Hallin, 2002). There was a competition between the hospitals, especially between Östra and Sahlgrenska, not for patient care, but rather for status and reputation. Before the hospitals were merged, all of the hospitals had experienced financial difficulties for many years (Hallin, 2002).

4.1.2. The merging process begins

After the general elections in 1994, the Social Democrats gained the majority in the county councils of Gothenburg City and Bohuslän. The majorities of Social Democrats in both councils created the opportunity for the politicians to discuss more cooperation between the councils, and the discussion led to talks on how they could give the best possible medical and health care to its inhabitants without increasing funding into the

health sector. This is according to a trend in Sweden during the 1990s, where series of restructuring of hospitals took place (Ohlsson, 2001).

The politicians wanted to achieve a synergy effect by merging the hospitals (Hulte & Thång, 1998). In the autumn of 1994, the councils of the city of Gothenburg and Bohuslän decided to find out if a more active cooperation between the hospitals in the large Gothenburg area was possible. Therefore, the politicians of the two councils established the SISIS project to examine the advantage of more cooperation between the hospitals. Professionals and officials were driving the SISIS project. There were over 700 people involved with the project, and all had one or another connection to the former three hospitals which were about to merge (SISIS, 1996).

The prerequisites for more cooperation between the three hospitals as follow: That the medical care should be as good as possible and that the new hospital should give the large Gothenburg area excellent hospital care with highly specialized services. Furthermore, the hospital should give its personnel the possibility to develop and focus on research and teaching, and the money available for healthcare should be used in the best interests of the patients (SISIS, 1996). The main condition of these changes was that the new structure of the hospital should benefit the patient. It was this patient perspective along with the economic elements that were the main reasons for the changes.

During the development and conclusion of the SISIS project, it became clear that one of the goals of more cooperation between the three hospitals was saving money. To achieve that goal, the politicians in both councils recommended merging the three hospitals into one, with one board and one director. The directors of the three hospitals made it clear in the SISIS closing report that further rationalization of the economy was impossible in the three hospitals without decreasing the quality of the care. They based their views on their own experiences, citing demands for savings, personnel fatigue and endless demands for greater efficiency (SISIS, 1996).

The officials in the SISIS project listed the advantages and disadvantages for merging the three hospitals. In general, there were much more advantages than disadvantages

with the merger. If details of the advantages and disadvantages are looked at closely, the officials found many advantages for the patients with the merging, like higher quality of care. The main disadvantages were that certain services which all of the three hospitals provided could move to one hospital. The consequence of this was that it would take more time for the patient to get the service. The officials only saw advantages with the merger for the economic side of the SU. The economic advantages were the possibility to focus more on high technological medical care, better cooperation of the medical care, more active work with the treatment and care processes, higher quality and more specially educated personnel, and streamlining of the hospital to get better economic results. The personnel would have the opportunity to develop professionally, there would be greater opportunity to change roles among the personnel, there would be more opportunities to change work tasks among the personnel, and provide greater stability for the personnel (lower personnel turnover). The disadvantages for the personnel were that there would be fewer positions on certain levels, for example on the managerial level, fewer needs for certain specialized personnel, and, overall, fewer personnel to achieve the hospital goal of high quality care. The SISIS project officials also warned that the changes could create anxiety among the personnel (SISIS, 1996).

The officials of the project of SISIS made recommendations regarding how the information and communication in the new hospital should be organized. The personnel should be informed about the merger and decision and reasons for the merger must be given to the personnel. In addition, the management team should secure the build-up of a good communication and information system, with good flow inside the organization (SISIS, 1996).

There was no demand for saving or cost cutting when the SISIS project began from the political side. The purpose of the SISIS project was to improve the access to the health care, cut the waiting times for treatment and appointments with physicians and improve the quality of the care. In the summer of 1996, the owners (the politicians in both councils) demanded a decrease in the operational budget of 500 million SEK in the first three years. Suddenly the demand to cut costs and economize the new hospital was clear. According to the personnel, the reason the politicians did not reveal the demand for cost

savings sooner, was their concern that the merging process would have a more negative reaction (Hallin, 2002).

The Director and the Chief Physician for Östra protested against the idea of merging the two big hospitals in Gothenburg (Östra and Sahlgrenska). They said the economies of scale by merging the hospitals were little if anything. The saving in administration would be insignificant; rather the merger would create a gigantic administration unit for the two hospitals. The two hospitals were already efficient in the operation of their clinical work and the merger would not increase the efficiency there. They referred to the ideal size for a hospital, which was hospital with 500-600 care beds and said that the cutting in operation costs in the three hospitals would not be achieved by merging the hospitals into one. When the officials of SISIS were formulating their proposals, a series of articles were published. In these articles, the proposals and ideas were protested, such as the proposal of merging the three hospitals into one would gain more efficiency. This criticism made the work of SISIS difficult. The criticism of the work was harsh and in some way effective. The idea of closing one of the Emergency Units was not developed further when the physicians opposed it. The media was negative and published news about concerns among the personnel with the merger and its foreseeable economic problems (Ohlsson, 2001).

4.1.3. The merger

The merger of the three hospitals into one created one management team with one director instead of three. The management team consisted of 10 divisions and the divisions had activities in the three main buildings of the old hospitals (Ohlsson, 2001). In August 1996, the director for the new hospital began to work. He was efficient in formulating the goals and vision for the hospital, but criticized for neglecting the real work of steering the organization and implementing the merger (Hallin, 2002).

The new director formulated plans about how he thought the new hospital should work. First, the new hospital should give the best possible care with the given resources. Sec-

ondly, SU should be a leading hospital and research centre, an attractive workplace where personnel could develop their competence. Thirdly, a strong and competent divisional structure should be developed for the SU. Fourthly, the management team should be active in working with the personnel, communicating with the personnel, be informative and cooperate with each other and with the personnel (Hallin, 2002).

The new ten divisions were given a name in an alphabetic order. The divisions were structured after organs, age or function orientation. Each division had activities in the three main hospital buildings. Every division had its own manager, who was part of the management team of the hospital. Every division had administration staff and was built in a hierarchical structure. The reason for dividing the new organization into divisions was to make coordination and reorganization better in the new organization (Hallin, 2002).

The politicians set goals for volume of care, which were the same as the three hospitals had in the year 1995. The hospital board decided in December 1996 the budget for the hospital for 1997, which was suppose to be negative by 60 million SEK. There were no extra funds given to the SU to implement the merger. All costs that were incurred relating to the merging process would come from the savings from the merger. Furthermore, because of the turbulent effect that the merger had on the personnel, the production capacity decreased in the first year. The critical factor was that the directors of the divisions did not have full control over the divisions' economy. They just had control over the cost, not the revenue. In the old hospital structure of Sahlgrenska, Östra and Mölnadal the department's manager had control of both revenues and costs. It was difficult to meet the demand for cost cutting in 1997, when the managers, who were responsible for the cost cutting, were not recruited until September 1997 (Hallin, 2002).

4.1.4. After the merger

The new hospital was not creating better access to health care or better quality of care. One of the main goals of the merger was to save money, to economize the organization's activity. The new hospital did not save money, quite the contrary; it had an enor-

mous budget deficit in its first few years of operation. This budget deficit, the problem with the new organizational structure, and a frequent change of directors led to new organizational change in the year 2000 (Brorström, 2003).

Table 1. Annual reports from SU 1997 to 1999 showed the hospital financial problems:

	Year 1997	Year 1998	Year 1999
	Result*	Result	Result
Revenues	5,884	6,250	6,977
Expenditures	6,326	6,770	7,220
Profit / Deficit	-442	-520	-243

* All numbers are in SEK (Millions)

The budget deficit in 1997 had many causes. First, there were difficulties with adjusting different organizational cultures to each other and secondly, the implementation of organizational change at the same time as efforts made to reduce costs and maintain the volume of care of the year 1995 proved to be an impossible mix. The budget deficit of the year 1998 had three main reasons. First, the hospital produced more care without being compensated for the extra production. Second, there were problems in the management team, which lead to inefficient purchase of goods and services. Thirdly, the personnel costs were higher than expected, mainly because of more production and problems in recruiting more personnel. The budget deficit of the year 1999 had mainly the same problem as in 1998 (Sahlgrenska annual reports, 1997-1999).

Table 2. Number of personnel

	Year		
	1997	1998	1999
Number of personnel	16093	16742	16982

* Number of personnel are all personnel, full time and part time

The number of personnel rose by 5% in the period of 1997-1999. The biggest factors in increasing numbers of personnel varied. One was increasing production of care, which the hospital was not compensated for (Sahlgrenska annual reports, 1997-1999).

The SISIS report had obviously been too optimistic. The real motive for the merger was not creating a hospital that is more effective; rather it was breaking up the traditional

treatment processes in the hospital, which the medical specialists decided, by implementing new treatment processes and changes (Ohlsson, 2001).

Everybody who was interviewed in the study by Hulthe and Thång knew that the new hospital would not get more money for the operational costs. The new hospital would have to use the same budget, such as the total budget of the three hospitals earlier. The merging process took a short time. The disadvantage of this was that the personnel had problems identifying with the new organization and lacked information about the merging process. In the merging process, it took time to fulfil all the managers' positions and the personnel worked too long without a clear and firm leadership. The personnel were tired of the merging process; they thought it was a waste of valuable resources by not having the managerial team clear from the beginning. The personnel felt insecure and had a lot of unanswered question such as "Who is the director for the department?", "What will the new hospitals be like?" "How will it affect the work of the personnel?" (Hulthe et.al., 1998).

In the Hulthe and Thång study, the people who were interviewed mentioned the cultural differences between the personnel in the three different hospitals, which could explain partly the problems that occurred in the merging process. One of the informants pointed out that the cultural problem was a foreseeable problem, because the hospital in Möln-dal was a patient-oriented hospital, while Sahlgrenska was a research-oriented hospital. The informants also thought the merger would have positive effects. The larger hospital could take care of more number of patients and patients with rare diseases. It would be possible for personnel to exchange information and knowledge and therefore increase the personnel potential for research. The merger would give SU and Gothenburg a larger role and status on a national and international arena. Most of the personnel were however conscious about the budget deficit, which the three hospitals had. One of the main factors of the merger was to lower the costs of care, so the new hospital's revenues could meet the costs. Most of the informants in the same study said that the demand for saving came gradually after most of the organization change had been presented and approved (Hulthe et. al.,1998).

Many of the personnel interviewed in Hallin's study said that the reason for the new hospital having economic problems from the start was that the economic director for the hospital did not start until October 1997; ten months after the hospital started operation. The new common financial system was not implemented until January 1998, one year after the new hospital started its operation (Hallin, 2002).

One of the main methods of cutting cost was decreasing the beds of care. The hospital managed to cut the number of care beds by 150 in the year 1997. That led to another problem, the shortage of caring beds. The consequence of this was that operations had to be postponed because there was no bed of care for recovery for the patient. This situation was described as chaotic. Instead of focusing on taking care of the sick, the personnel were using valuable time finding a bed for a patient. The result was that the hospital did not have a sufficient number of beds to fulfil the demands of a certain volume of care (Hallin, 2002).

According to Hallin many of the personnel were generally negative and sceptical about the merger, the division structure, and its consequences for them and their workplace. The restructure of the hospital into the divisional structure meant that many personnel had to change their place of work and their working colleagues. This led to uncertainty among the personnel, and many of the personnel felt that they were forced to change and accept the new working conditions (Hallin, 2002).

The merger of the three hospitals meant that the organizational structure of the three hospitals was abolished and for personnel in Östra and Mölndal and the distance between personnel in those two hospitals and the management team became wider because the director and the management team was mainly stationed in Sahlgrenska old main buildings. The hospital management team wanted to keep the personnel informed about the merger and hospital issues. To achieve that, the personnel received a magazine called *Substans*. According to Hallin many of the personnel said that the magazine gave too positive picture on what was going on in the hospital and how the merger was successful. There was a big difference in what the personnel read in the magazine and what they experienced in their workplace at the hospital (Hallin, 2002).

The personnel felt that the hospital director and the management team had no idea what was going on in the hospital, and dissatisfaction among the personnel grew. In reality, the management team fully realized the situation in the hospital and the director complained to the politicians in the council about the tight budget that they had decided for the hospital. The director said that the budget balance was an admirable goal, but had no meaning when the personnel in the hospital worked hard in a difficult financial situation to cure and care the patients. The people interviewed agreed that the economical development and the structural changes in the hospital undermined the trust from the personnel to the director and others in the management team (Hallin, 2002).

The merger of the three hospitals and creation of one common organizational structure meant that many managers of the old organizational structures lost their jobs in the new hospital, because positions on the manager's level decreased more than 60%. Many of those who lost their positions were unhappy with the merger. The director made it clear that the managers of each division could not have another position. The medical professors, who in the old structure had both been professor at the medical faculty and had a manager's position at one of the hospitals, mainly old Sahlgrenska, criticized this (Hallin, 2002).

In an operational sense, many expected that the new structure would lead to more involvement and better communications with the divisional directors, as the director had prioritized. These expectations turned into disappointment because the divisional directors' involvement in personnel activities was minor since they were occupied with economic issues. One division manager admits in Hallin's study that the focus on the economy and cost cutting took all his time and he had no time for other issues like developing the quality of care or listen to personnel proposals. There was no dialogue about work, work routines or increasing quality, only discussion about the economy, and how to balance the budget (Hallin, 2002).

According to Brorström (2004), some chief physicians claimed that the merger and the establishment of the new hospital had torn up well functioning hospitals and built new

walls inside the new organization. The chief physicians said that opportunities to stimulate the personnel had decreased with the new structure of the hospitals, unlike the older structure. This increased the personnel dissatisfaction with the merger, especially where their small opportunity to influence their own work was abolished. This dissatisfaction increased among the personnel, when the workload increased, and negative morale increased in the new organization. The chief physicians said the new structure characterized by insufficient communication in the organization. This goes against the essence of professional bureaucracy, where the professionals have autonomy in their work and can influence their working environment (Brorström, 2004).

A cross-section of personnel working in SU evaluated the situation in SU from the personnel point of view in May 1998. The group judged the situation in the SU as serious. The pace of work was high, the working conditions of the employees were oppressive and a shortage of care was hurting the patients. The decision to merge the three hospitals was questionable among many of the personnel from the beginning. The expectations of the merger were too high. The resources to complete the merger successfully were however lacking, and necessary discussion about the merger had not taken place. The merger lacked a connection to reality, it was too theoretical and this led to problems in daily activities in the new hospital (Tvärssnittsgruppen, 1998).

Many informants in the study by Brorström and Hallin mentioned that the budget deficit created bad working conditions in SU and many competent personnel left the hospital permanently because of the bad working conditions in the hospital. The director and the management team lacked the capability to implement the merger successfully, because they lacked the resources to do it. The savings demanded were too much and the merging and recruiting process was too slow. Furthermore, the majority of the personnel had difficulty in understanding the assignment of merging the hospital. The personnel felt that the demands of cost cutting were a threat to their working environment, and to maintaining a high quality of care (Brorström & Hallin, 2002). One of the issues that the personnel found difficult to understand, was the demand for greater efficiency in the hospital. The personnel saw this as unrealistic. The process of making the new hospital more effective resulted in a complete reversal (Hallin, 2002).

The board of Sahlgrenska University said in its report in 2000, that the structure of SU was too complex. The organization had linear responsibility that included service in all three main buildings. There was no common vision or goal for the hospital, which was accepted in the hospital. The situation for the managers, personnel and the patients was extremely confusing. The management of the new hospital had not been according to plan and there was disorder in the hospital's finance. The board therefore recommended restructuring of the hospital (SU sjukhusledning, 2000).

The new organizational structure, which was implemented in 2001, was simply correcting the mistakes that were made in the merger in 1997. The organizational structure of divisions was not working. As one person stated, it was "a total fiasco". The divisional structure was focused on the organizational activity and not on the patients. The merger in 1997 made many personnel lose their trust in the organization. Many personnel could not identify with the SU as a hospital, but they still identified with their older workplaces, which were the hospitals in Sahlgrenska, Östra and Mölndal. The organizational change in 2001 was to increase the employee's identification (*sense of belonging*) within the organization (Brorström et.al., 2002).

4.2. The Icelandic merger

This section is organized similar to the previous section. That is, the chapter starts with a general introduction to the merger after which the motivation for the merger are described and analyzed. Then the actual merger is reviewed followed finally with a discussion and analysis of the outcome.

4.2.1. General information about the hospitals

The Landspítali-Háskólasjúkrahús (LSH) was established in March 2000. The merger was completed in steps. The first step was to merge the hospital Landakot and the hospital Borgarspítali in 1996 into one hospital, Sjúkrahús Reykjavíkur. The second step was to let Sjúkrahús Reykjavíkur and Ríkisspítalar-Landspítali be managed by one general director, while the board of both hospitals still existed. Thirdly, in March 2000, the two hospitals were completely merged into one hospital under one board and one director with one organizational structure. The Ministry of Health did not engage in the merging process. Rather, it was the boards of the hospitals that designed the merger, and the boards who made proposals to the Ministry regarding the progress of the merger. The new organizational structure consisted of one director and five managers (Landlæknisembættið, 2002).

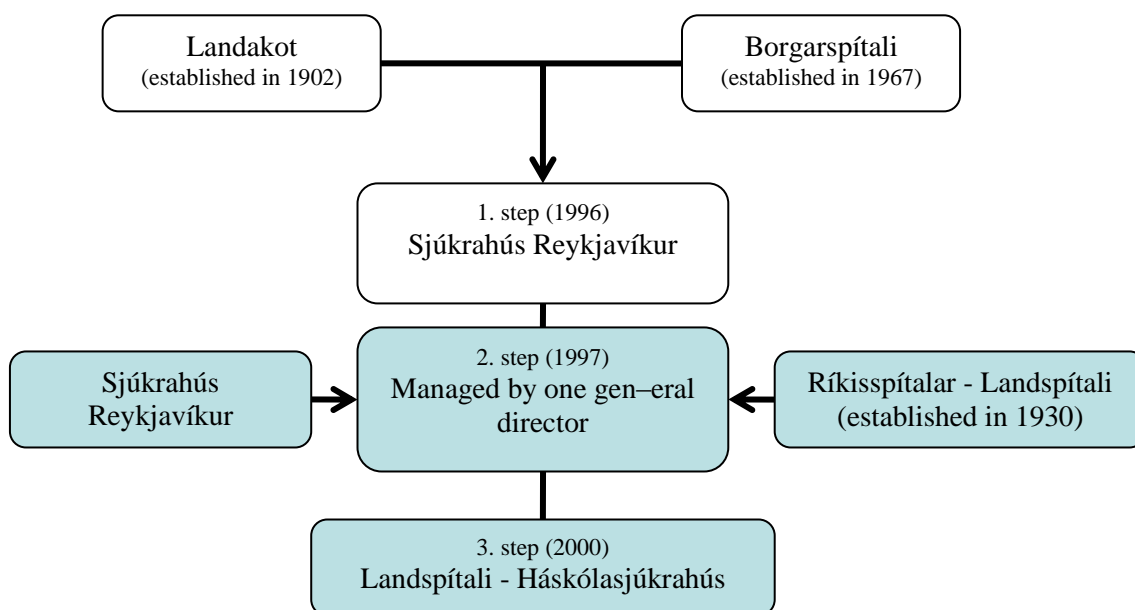


Figure 2. The merger process of the Icelandic hospitals

The structure of the new LSH abolished the structure of the older hospitals. LSH became Iceland's biggest hospital and Iceland's biggest organization. LSH was responsible for giving high-technology health and medical care to all inhabitants of Iceland (serving the whole population of Iceland, 300,000 inhabitants) and be a regional hospital for Reykjavík and the city's suburbs. The hospital works closely with the University of Iceland in educating health professionals and is the center for medical research in Iceland. In the year starting 2000, the hospital's budget was around 20 billion ISK, the number of personnel was 4200 and the hospital had over 1200 beds of care. The LSH has used the same percentage of GNP, in the period of 1999-2002 or around 2.8%. The LSH is about 30% of the healthcare expenditures of the state budget and about 10% of the total state budget (Ársskýrsla, LSH 2006).

Discussion of greater efficiency among the hospitals in Reykjavík started in 1991. At that time, there were three main hospitals in Reykjavík, Ríkisspítalar-Landspítali, Borgarspítalinn and Landakot. The state owned Ríkisspítalar-Landspítali, the City of Reykjavík owned Borgarspítalinn and Landakot was owned by a self-governing Catholic nuns' organization. The state paid all the operational costs of the hospitals. The two hospitals, which were not owned by the state, received payments according to an agreement with the state.

The new organization LSH was defined as a high-technology hospital, which should serve all the inhabitants of Iceland and be an area hospital for Reykjavík and its surroundings. The new hospital should be a centre for medical research and medical and health education in close cooperation with the University of Iceland. According to the law, from 1990, Ríkisspítalar-Landspítali was a university hospital and professors of medicine at the University of Iceland automatically became chief physicians at the hospital. With the new 'agreement of cooperation' between LSH and the University of Iceland from 2001, the rule of professors being chief physicians was abolished. The advantage of more cooperation and the merger of the hospitals is that the knowledge of medi-

cine is gathered in one place and the cooperation between the hospital and the university is on a formal basis. The hospital is a place where many physicians and most other health personnel are educated. Each year the hospital teaches over 1000 students in health related studies, such as medical physiology, nursing, midwifery, studies for laboratory technicians and pharmacology (Ríkisendurskoðun, 2003).

4.2.2. *The merging process begins*

The 1990s were a difficult time for the hospitals in Reykjavík. They all had financial problems and endless reports of increased cooperation between the hospitals were lowering the morale amongst the personnel in the hospitals. For instance, the government decided in 1995 to make further cutbacks in funding to the three hospitals to rationalize the health sector in Reykjavík. One consequence of this financial rationalization was that medical specialists left the hospitals to their own private clinics that were possible under the new Healthcare Act of 1990. This led to a large increase of payments from the state to private medical specialists (Sigurgeirsdóttir, 2005).

There was one obstacle in making the hospital service in Reykjavík more effective. The nuns, who owned Landakot, had made a financial agreement with the state in 1976 for twenty years. The agreement said that the function of Landakot should be unchanged for the given period. The Mayor of Reykjavík made a proposal to sell Borgarspítali in 1986 to the state. The mayor was concerned about the escalating costs and the budget deficit of the hospital, and believed that responsibility for finances and administration should be combined. Therefore, since the state paid all the operating costs of the hospital, but not the deficit, the state should have full control of the hospital. The proposal received a hostile reaction among those who worked in Borgarspítali, especially from the physicians and the proposal subsequently was withdrawn (Sigurgeirsdóttir, 2005).

In the spring of 1995, a new government gained power in Iceland. The Minister of Finance was interested in ideas of New Public Management. In the autumn of 1995, the Minister of Health appointed the director of Ríkisspítalar-Landspítali as a new permanent secretary for the ministry, which became enthusiastic about merging the three hos-

pitals into one in Reykjavík (Sigurgeirsdóttir, 2005). From 1991 to 1998 there were five committees established to estimate the costs of more cooperation between the three hospitals. One report from these committees showed that if the all the hospitals were merged into one, the personnel could be decreased by 13% (Ríkisendurskoðun, 2003).

Because of the work of these committees, Landakot and Borgarspítali were merged into Sjúkrahús Reykjavíkur at the beginning of 1997. The merger process also started with Ríkisspítalar-Landspítali to avoid duplication of work. This led to an agreement in late 1997 to establish a specialist geriatric service in Landakot for the whole Reykjavík area, and this would receive patients both from Sjúkrahús Reykjavíkur and from Ríkisspítalar-Landspítali. Further relocations and reconfigurations were scheduled to be discussed and implemented according to this agreement.

In 1997, the Ministry of Health ordered a report from a consulting company. The report laid out the advantages and disadvantages of merging all three hospitals in Reykjavík into one big university hospital. This report changed the discussion about more cooperation between the three hospitals. Instead of parties of interest being against the idea of one big hospital, the parties of interest (especially the physicians) started to debate in the media the advantages and disadvantages of establishing a university hospital. The idea of establishing one big university hospital had its supporters among prominent physicians and leading nurses. The Minister of Health was becoming more and more convinced of the advantages of merging the three hospitals into one (Sigurgeirsdóttir, 2005).

4.2.3. *The merger*

At the beginning of 1998, a working committee was established to explore further cooperation between the hospitals. In December 1998, the Mayor of Reykjavík, the Minister of Health and the Minister of Finance signed an agreement to implement a full merger of the three hospitals in Reykjavík. The agreement was based on the proposals from the working committee, and according to the agreement, Sjúkrahús Reykjavíkur should merge within one year with Ríkisspítalar-Landspítali and one general director

would be hired for both hospitals immediately. The agreement was made in utmost secrecy to avoid opposition (Sigurgeirsdóttir, 2005).

At the end of 1999, it was decided to have one board for both hospitals. The Minister of Health gave the board of the new hospital, and its director, a directive to form a new organization chart for both hospitals. The boards of both hospitals approved the director's proposal for one organization chart for both hospitals and requested that the Ministry of Health would prepare to merge both hospitals. The Minister of Health approved the proposal for the organization chart and gave a directive in February 2000 to merge the two hospitals into LSH. The Minister of Health confirmed the merger on 3 March 2000, by special regulation. The new hospital was to start operations the same day as the regulation was issued (Ríkisendurskoðun, 2003). According to the board of LSH, it was mentioned that many of the personnel were active in the merging process and made valuable recommendations regarding the merger (Landspítali-Háskólasjúkrahús, 2003).

By merging the two hospitals into one, opportunities were available for decreasing the operational costs, mainly through having fewer personnel, through merging departments, through less renewable need of hospital equipment and through decreasing overtime by the personnel. Therefore, it was expected that by merging the hospitals would lead to the economizing its operations. The real result was that the merging of the hospitals increased the costs of operations, instead of decreasing it. The reason for higher costs was better and more expensive technology, new medicine and increases in salary costs, but in accordance with the price index. The biggest advantages of the merger, according to interviewers in a study conducted by the Icelandic National Audit Office (IANO) 2003, was the merging of the specialist subjects of medicine. The merger made it possible to build up bigger and more professional units that were fully comparable to the best international standards. The new hospital structure was simpler than before, and duplication of work has reduced. This resulted in better service for the patients and more and better opportunities for research and for scientific work. Therefore, the work and the shifts in the departments could be organized better. This gave an opportunity to organize the shift system of the personnel in a better way and could save 150 million ISK on a yearly basis (Ríkisendurskoðun, 2003).

On an administrative level, the management team put a lot of effort into improving the administration of the new hospital. The clinical managers did not have other jobs, as was common in the old hospitals. The managers believed that the new hospital personnel were more disciplined than in both the earlier hospitals. With the merger, the managers gave the departments' financial responsibility and every department of the new hospital had their own financial coordinator to improve the cost awareness among personnel. The departments of technology, building supervision and computer services were merged and the top management level reorganized with new organizational structure. This effort led to decreasing number of personnel by 20% in those departments. Most economizing work was abolishing and restructuring few kitchens and standardizing all inventory equipment (Ríkisendurskoðun, 2003).

The Health Minister said in 2003 that the build-up of Landspítali-Háskólasjúkrahús and its development was not only about economizing the operations; it was also about the better use of financial resources, and to create a strong university hospital. The merger of the two hospitals was a result of the publication of reports and ongoing discussion for one decade, and therefore the merger could not be a surprise to the personnel or the public. The decision was made to merge the hospitals, and it was known beforehand that the merger of specialties of medicine would be difficult, and groups of the personnel would protest the merger. The merger would bring more benefits for the hospital, for the capital area and for the country as a whole. The Minister of Health mentioned that it was generally acknowledged that the best circumstances for hospitals to work in are where the patient base is from 700,000 people to 1.2 million people. It must be remembered that the LSH is the general high-tech hospital that is supposed to provide the best care available, and the patient base is a little over 300,000 people (Heilbrigðis- og Tryggingarráðuneytið, 2003).

4.2.4. *After the merger*

In the Health Minister's directive for the new hospital said that LSH "should be a strong organization, which gives concentrated and efficient care for the benefits of its clients." The INAO criticizes that no goals of the merger were measurable. The INAO claims that the hospital's future views are unclear, while a clear vision of the future is necessary to guide such a complicated organization. The Ministry of Health said in a press release that the merger was to make the administration and the operation of the hospital more efficient and improve service to the patients. The merger would give the new hospital the potential to give the best possible treatment, care and service for those who need it. The hospital would be better prepared to meet new challenges of better health-care, meet future challenges like increasing number of patients, and meet new competition for personnel from abroad. The merger would give the inhabitants of Iceland better access to a high-technology hospital.

Even if the goal of the merger was not stated clearly, the intention of the merger was as follows:

- Make the operation of the hospitals more efficient and cheaper
- Increase the quality of the service and the patients' wellbeing
- Strengthen the role of research and teaching inside the hospital.

The arrangement of the merger was disputed. Should both hospitals be merged into one building, or should the specialized service of the new hospital be divided between the hospitals and the emergency and routine service be divided? It was decided to merge the hospitals and divide the healthcare service between the two hospitals' main buildings (Ríkisendurskoðun, 2003).

There was little or no opposition against the merger among the personnel. The discussion about advantages and disadvantages for the merger had taken place between the physicians in 1997. Those who opposed similar ideas in 1996 had resumed other positions or retired (Sigurgeirsdóttir, 2005).

According to Sigurgeirsdóttir, the Icelandic State took over Sjúkrahús Reykjavíkur and merged it with Ríkisspítali-Landspítali hospital. After the merger, LSH has a monopoly in the Icelandic health market. LSH can control its service capacity, its operations, operate a high-technological hospital and have effect on the health policy (Sigurgeirsdóttir, 2005). In a study made by the Ministry of Health in 2003, one physician said the merger gives the new hospital a monopoly and the competition which existed between the two hospitals before, was abolished with the merger. In the end, this monopoly could lead to less service because of the lack of incentive that the competition had (Heilbrigðis- og Trygginaráðuneytið, 2003). The Icelandic Medical Association and others interest groups did not respond to the changes of the structure of the hospitals.

Former chief physician of the Ríkisspítalar-Landspítali, wrote that in the end this monopoly will not be good for the hospital, its patients and physicians and added that the merger has not been as effective as supposed. Rather the merger led to little efficiency and less performance in the form of less beds of care and fewer staff. The IANO said in its report on LHS efficiency in 2004 that physicians who were against the merger should leave the hospital for good and work somewhere else. The question is where these physicians should go. LSH is the only hospital of its kind in Iceland as there is no other hospital with the same functions; in effect LSH has a monopoly (Helgason, 2006).

In 1998, the Minister of Health said during the Icelandic Medical Association's annual meeting that there was not a political consensus in the parliament for merging the three hospitals. The minister wanted to develop more cooperation between the hospitals and try the system with one general director for both hospitals. The Icelandic Medical Association agreed to let a committee see what possibilities there were for more cooperation between the hospitals. The committee said in its conclusions that there was a trend for merging the hospitals, without clear strategic planning. The Icelandic Medical Association was split regarding the question of for or against the merger, but subsequently took the 'no' position regarding it (Sveinsson, 2006).

One of the LSH problems was the patients who had been treated but needed some nursing home to recuperate. The hospital took care of these patients, although they should

be in a nursing home, not in a high-technology hospital. During 2002, these patients used an average of 175 beds out of a total of 959 beds. This is a heavy burden for the hospital, as there is a shortage of beds, and it would cost less money if the patients would recuperate in a nursing home. Moreover, the hospital does not get any extra financial support for being a teaching hospital. It has been estimated that the cost of teaching is around 3-5% of the total costs of the hospital or around 1,100 million ISK (Ríkisendurskoðun, 2003).

The rationalization of the merger, according to those who decided to merge, was to cover all costs of the merger. Therefore, there was no extra funding provided to meet the cost of the merger which was over 400 million ISK. The merger had direct costs for the new hospital, such as paying out payments for staff that left. There were also building costs and the cost of the computer system that were not included (Ríkisendurskoðun, 2003).

Table 3. The annual reports of LSH from 1999 to 2002 shows the economy was improving.

Landspítali-Háskólasjúkrahús				
	Year 1999 result	Year 2000 result	Year 2001 result	Year 2002 result
Revenues	19,013,553	19,855,839	22,217,424	26,156,510
Expenditures	19,167,797	19,909,282	22,704,895	26,095,961
Profit / Deficit	-154,244	-53,443	-487,471	60,549
* All numbers are in ISK (thousand)				
	Year			
	1999	2000	2001	2002
Number of personnel	4,134	4,127	4,019	3,913
** Number of all personnel, full as part time				

In 2002, the surplus in operating the hospital was mainly because of extra funding from the government to meet the hospital budget deficit. The number of personnel has decreased by 5% in the period of 1999-2002. The cost of operating LSH has not increased if the price index is considered (Ársskýrslur Landsspítala-Háskólasjúkrahús, 1999-2006).

LSH expenditures show that 64% of the expenditures are salaries of the personnel. It is vital for the economics that the personnel situation is in good order. The hospital salary increased 30% in the period of 1999-2002 (at the same time the general salary index rose by 24.5%). This happened at the same time as there was a decrease in personnel in 2002 compared to 1999 and cost of overtime decreased by 20% during the same period. Costs of medicine are around 9% of the hospital's total budget (Ríkisendurskoðun, 2003).

The financial grants from the government to the hospital increased by 37% for the period 1999-2002, but the price index rose at the same time by 17% and the salary index by 24.5%. The reasons that the hospital has needed extra funds are higher salaries, higher costs of medicine and plans that have not been reliable (Ríkisendurskoðun, 2003).

The LSH is financed by a fixed budget system. The fixed budget system has one major disadvantage: lack of incentives. When LSH was established, few departments of the hospitals had been financed by the so-called DRG system (Diagnose Related Groups). This system gives the opportunity of comparing the hospital performance within the country and also between countries (Halldórsson, 2003). The government was in 2005 not ready to pay LSH according to its performance, so the financial budget from the government to the LSH was in the form of a fixed budget. The government was afraid that if the LSH would receive payments according to performance it would lead to an unlimited supply of health services, which would lead to a huge increase in the costs of the health services (Morgunblaðið, 2007).

The output, or the performance, of the new hospital, measured in 2003, showed that the provision of services is at the same level as before the merger. The productivity per person had increased little. The costs of operation had increased so the hospital is run today with less service for each Icelandic króna than before (Ríkisendurskoðun, 2003).

A committee was established in 2001 to explore all possibilities regarding the future location of the new hospital. It has been calculated that the operating cost would be 10-

15% lower if the hospital is operated in one area. The committee was convinced that the full efficiency of the merger would not be reached until the hospital was based in one place. It would benefit the patients, the next of kin, the personnel and those who have connection with the hospital. This would lead to enhanced cooperation between medical specialties and the further concentration of medical knowledge will benefit the patients. Therefore, they proposed that the future placement of the new hospital should be in the Hringbraut area, where Ríkisspítalar-Landspítali was located. Of the available choices, the cost of renovating the hospital was lowest in Hringbraut for the future placement of the hospital (Heilbrigðis- og Tryggingarráðuneytið, 2002).

The process of the merger was over by the end of 2002, according to a plan created in 2001. The reason that the merger process took such a long time was the lack of funding and certain resistance from the personnel and others against the merging process. The personnel were disappointed and insecure with the merging process, but after the process was over the uncertainty and disappointment among the personnel diminished. The personnel saw the positive potential with the merger soon after the merging process was over and how much opportunity the merger had for development in the future (Ríkisen-durskoðun, 2003).

A team of managers of LSH made an assessment report on the situation in LSH in 2004.

According to the team, the merger led to many positive factors such as:

- Larger professional units, which has strengthened the knowledge of the personnel.
- A decreasing number of personnel.
- A simpler shift system, both for personnel and managers.
- A decreasing number of beds by 25% in three years and better use of beds.
- An increasing productivity in the hospital and shorter waiting lists.

According to the team the negative factors of the merger were, among others:

- No strategic plan or policy was available for the future.
- The merging process had been costly and taken too much time.
- No extra funds were given to meet the costs of merging.

- The managers were too occupied to get extra financial support to balance the budget.
- The operating cost had increased, mainly in the form of higher salaries.
- The merger had not led to a full use of the hospital facilities, for example surgery.
- The hospital operated two emergency units, which is very inefficient.
- The government's goal that the merger "was to stop the increasing in operation costs of the hospitals, which would lead to more efficient organization in the future" was questionable (Team of directors, 2004).

The Office of the Chief Medical Officer assessed the situation in the Landspítali-Háskólasjúkrahús (LSH) in 2002. The decision to merge was made after a decade of discussion and reports about more cooperation between the hospitals. The purpose of the merger was to make the new organization better organized and better administrated, so the service to the patients could be improved and the hospital could give good care in accordance to international standards (Landlæknisembættið, 2003).

According to the Chief Medical Officer, LSH is an emergency hospital and like other emergency hospitals, their operation has in recent years changed and become heavier in operation. Length of stay is decreasing but the medical pressure on the patients that stay has increased. Departments that give daily care perform more and more of the hospital services. The hospital stays increased by 2.6% in the period of 1999-2001 but the length of stay decreased by 10% because of better technology, as did the average number of patients per day. The shorter length of stay means that the treatment of every patient takes less time, and therefore it can be assumed that those who stay in the hospital are much weaker than before and therefore need more attention and service (Landlæknisembættið, 2003).

The Chief Medical Officer compared the number of personnel of the three earlier hospitals in 1990 to what they were in 2001. The comparison showed that the personnel had decreased by 5% in that period. The number of physicians and nurses had increased by

10%, personnel in administration were 30% more in 2001 than in 1990 and other personnel, like cleaning and kitchen had decreased by over 30%.

The number of beds in the three hospitals were around 1500 in 1990, but in 2001 the number of beds were around 1000, a decrease by 30%. The personnel turnover (proportion of the personnel that quit in a certain period) was 25% in 2001, which is rather high. Absence because of sickness is over 5%, which is a high percentage (Landlæknisembættið, 2003).

The Chief Medical Officer conducted a survey in 2002 to measure the personnel's well-being and their attitude towards LSH, showed that around 70% of the respondents in the study can handle their workload and over 96% believe that their work demands a lot of knowledge on their behalf. Over 75% respondents said their work is stressful, difficult and quick decisions need to be made. Around 50% of the respondents said they have poor working conditions to handle the patients and next of kin, and the same proportion of respondents say they have worse working conditions than before. More than 55% of the respondents say they are not involved in planning and policymaking. More than 55% of the respondents say that they received little or no information about the future policy of LSH and the merger plan. Groups of a similar size, around 42% of the respondents, were for and against the merger. Over 55% of the respondents said the purpose with the merger was unclear and the strategic plan for the future was unclear. Over 60% of the respondents said the merger was poorly executed and only 12% of the respondents said the merger was implemented in a good way. Around 50% of the respondents said the emphasis on research and scientific work is little or none in daily work (Landlæknisembættið, 2003). Over 90% of the respondents said they were happy in their work.

It says in the Chief Medical Officers assessment of the situation in LHS, it says that the merger was a difficult task, it would take a long time and there would be dissatisfaction about the merger. The Chief Medical Officer also wrote that it was important to note what the merger had accomplished. The creation of a new strong university hospital that is fully comparable to the best, from an international perspective. There are profes-

sional reasons behind the merger, and therefore the advantages of the merger should be focused on, advantages like better service, better knowledge and more research and scientific work in the new hospital (Landlæknisembættið, 2003).

5. Comparative analysis

5.1. What were the main reasons behind the mergers?

5.1.1. The reasons behind the merger in Gothenburg

The reasons behind the merging of hospitals in Gothenburg were initially to increase the cooperation between the three existing hospitals and to improve the access to health care in the Gothenburg area. There were no initial demands for cutting costs. They came later in the process. The goals of the merger were not very clear. There were expectations that the merger should make it possible to give the inhabitants of Gothenburg the best possible medical and health care by increasing the quality and improving the efficiency of care. In fact, it was believed that the efficiency of the new organization should make it possible to provide a higher quality of care for the same or less money than the three previous hospitals. The personnel of the new hospital should also have more opportunities to develop their skills and knowledge by participating in research.

5.1.2. The reasons behind the merger in Reykjavik

There were very similar reasons behind the merger in Reykjavik and the goals of the merger were equally unclear. The merging of the two hospitals was expected to make the operation of health care more effective, to halt the continuous increase of health care costs, to increase the quality of care given to the patients, and to strengthen the research and teaching role of the new hospital.

5.2 What methods were used in merging the hospitals?

5.2.1 The methods of merging used in Gothenburg

The politicians in the City of Gothenburg and the County Council of Bohuslän took the decision to have more cooperation between the three hospitals in Gothenburg area. A decision was also taken to establish a special committee of professionals and officials to monitor the SISIS project, which was to examine the advantages of more cooperation between the hospitals. Over 700 people who were connected to the three hospitals participated in the SISIS project. The officials of the SISIS project listed the advantages and disadvantages of more cooperation between the three hospitals in Gothenburg area and made recommendations to the politicians of the counties to merge the three hospitals into one, even after a demand for savings from the politicians came late in the project work. Based on the recommendation by the officials of SISIS, the politicians of both Gothenburg and Bohuslän decided to establish the Sahlgrenska University Hospital.

5.2.2. The methods of merging used in Reykjavik

In the 1990s there was an intensive discussion among politicians, officials and professionals about the need for more cooperation between the three hospitals in Reykjavik. In 1996 the privately owned hospital Landakot and City of Reykjavik owned hospital Borgspítali merged into Sjúkrahús Reykjavík. This hospital and Landspítali, which was the largest hospital, established in 1997 a common geriatric service for both hospitals. A report from a consulting company laid out the advantages of merging the two hospitals into one large university hospital. Based on the results from a committee, which was established to examine further possibilities for more cooperation between the two hospitals, the government of Iceland and the City council of Reykjavik made an agreement of more cooperation between the two hospitals. This cooperation was in fact recruiting one director for both hospitals, but the board and structure of the hospitals was still to be separated. A year later the two boards decided to recommend to the health minister a full merger of the hospitals with one board, one manager and one organizational struc-

ture. The merger process was driven mainly by the directors and the boards of the hospitals and the personnel of both hospitals participated in the merging process. The health minister approved the merger and gave the director of the hospitals directive to implement the merger.

5.3 Were the mergers successful or not?

5.3.1 The outcomes of the merger in Gothenburg

Compared with the goals and the expectations, the merger in Gothenburg did not go as planned. The operation costs were much higher than expected. Most of the managers recruited were too much occupied with economic problems instead of focusing on care, personnel, development and making the hospital better in a professional way. The new clinical structure of the hospital was chaotic, for both personnel and patients. There were frequent changes of managers. It was difficult to merge the organizational culture of the three hospitals into one. The merging process frustrated the personnel and they lacked a clear leadership. The communication system of the new hospital was not working properly, mainly because the managers had too much focus on the economy. A group of personnel said in report two years after the merger that the situation in the hospital was serious. The reduction of care, which was a consequence of the merger, was influencing the quality of care in a negative way. In fact, there are reasons to believe that the quality of care was decreased rather than increased by the merger. In 2000 the board of SU said that the new organizational structure of the hospital was too complex, the hospital lacked a common goal or vision, the hospital had continuous financial problems and the personnel, managers and patients were confused. The board recommended a total restructuring of the hospital.

5.3.2 The outcomes of the merger in Reykjavik

In contrast with the merger in Gothenburg, the merger of hospitals in Reykjavik went mostly as planned. The increasing health care costs were halted and the operation costs of the new hospital were mostly in accordance with the price index. The Chief Medical

Officer said in his assessment of the merger in 2002 that the health services to the population has been improved by the merger, the production of health care has increased, and the new hospital produces more research and scientific work than the two hospitals did earlier.

The Icelandic National Audit Office criticised the merger for lacking a clear vision and no measurable goals. It was also pointed out that there was no merger, but rather a take-over of the Sjúkrahús Reykjavíkur by the Landspítali. There is a little truth in these criticisms, because the structure of the new hospital, LSH, was in fact a developed structure of the Landspítali, where divisions were united and the traditional structure of the Landspítali kept in the LSH and the location of the LSH was where the Landspítali had been placed. Many were concerned about the size of the LSH and its unique position in the Iceland health care system. The LSH is Iceland's largest organization and the hospital takes one third of the annual health budget and ten percent of the total state budget. This could give the LSH a monopoly position in Iceland. Even though the merger was implemented, the LSH still had problems of taking care of patients who really could be cared for in a nursing home. The LSH is a university hospital and over 1000 health students are related to the hospital each year, and the hospital does not get extra fund for these students. A team of managers of LSH made an assessment in 2004 and they said that the LSH was a bigger professional unit, the number of personnel and beds had decreased, the hospital's productivity had increased and the waiting list for operations had been shortened. There were also signs that the quality of care of the hospital had increased by the merger.

In their assessment, the team of managers also mentioned some negative outcomes of the merger, like the lack of future vision for the LSH, the costs of the merging process, and the facts that the managers were too occupied with economic issues and the hospital did not operate at full capacity.

The Chief Medical Officer made an assessment, where the advantages and disadvantages of the merger were measured. The LSH was producing more than the previous hospitals. The personnel were five percent fewer after the merger than before, but the hospital had more physicians. The number of beds had decreased by one third. In the

Chief Medical Officer's assessment it became clear that the merger had been stressful for the personal and that a majority of the personnel had received little or no information regarding the merger. A big majority of the personnel (90%) said that they were happy in their work. The merger had created a strong university hospital with a high standard and the service given by the hospital was better than before.

6. Discussion

Both mergers described in this study were horizontal, since the same types of organizations were merged. There were similar reasons for the mergers, although they were not stated clearly reasons were economic. The hospitals in both cases were merged to get better economic results in their operations. The expectations of the mergers were also similar: the owners wanted synergy effects of the mergers, but in the Swedish merger there was added a high demand for savings in operating costs and high expectations of positive economic result of the merger. There were no numbers mentioned in the Icelandic case regarding how much the merger should save in operating costs, only that the increase of total costs should be halted, and the expectations of the results were modest.

There were great differences in the preparations for the merger. In Sweden, a special project (SISIS) was launched to investigate the possibility of further co-operation between the three hospitals, and it held meetings where over 700 people from the hospitals participated. The SISIS project developed the proposal of merging the three hospitals in Gothenburg. In the Icelandic merger, the decision of merging was made from above. It was said that the personnel of the hospitals that were merged had participated in the merging process. In fact, however, the board of LSH and its director drove the whole merging process. The Icelandic merger was part of a plan of centralization from the government. The general hospital, Ríkisspítalar-Landspítali, for example, made a takeover of Sjúkrahús Reykjavíkur, the Reykjavík city hospital. In Sweden, the SU merger was more a part of an ongoing trend in Sweden from the 1990s when New Public Management was introduced in Sweden.

Both mergers had similar problems of unclear goals in the implementation of the mergers. In the first years of operation, both hospitals also had operational problems in the form of cultural differences among their personnel. In both mergers, the managers and the management team were appointed late in the merging process. Personnel in both of the hospitals, LSH and SU, said that communication in their new hospitals was insufficient.

When the decision to merge the hospitals was made, the importance of a well functioning administration became more important. Both hospitals implemented a bureaucratic model, a model of 10 divisions in the Swedish case, and five in the Icelandic case. The mergers strengthened the role of the administrators at the expense of the medical profession of the hospitals. For example, the number of personnel in the administrative sector of LSH increased by 30% in the merging process. Both mergers resulted from discussions of New Public Management. However, there is a difference in the importance of NPM in these cases. It seems to have been more important in the Swedish case than in the Icelandic case. The SU operates its financial system through a performance-based system, while the LSH is mainly financed by a fixed budget.

Both mergers are good examples of the domain theory. There have been conflicts between the politicians, administrators and professionals regarding the policy of the new hospitals. In both cases there were no sign of similar views between these three parties on how to operate a hospital. The politicians wanted the health services to be as good as possible for the lowest price. The administrators wanted to operate the hospitals as efficiently as possible. The professionals wanted more resources from the politicians and the administrators to carry out their work in accordance with their professional standards. Both hospitals are classic cases of professional bureaucracy. Both hospitals also experienced problems after the merger in form of lack of communication, and a heavier workload on the professionals.

There was a general difference in attitudes towards the mergers. In Sweden, the merger of the three hospitals into one was regarded as a major change, like a revolutionary change. Everything changed, most importantly the implementation of a new clinical structure in the new hospital in Gothenburg. In Iceland, the change was more in the form of an evolutionary change. The main concept was to decrease the duplication of work in both of the hospitals concerned. There was no change in the clinical structure and there is a plan to build a new hospital on the grounds of the hospital that was the largest before the merger. Simply put, in Iceland the largest hospital expanded by the merger.

In both mergers there were no special funds allocated to implement the merger. Those who made the decision to merge thought that the economic gains resulting from the merger would pay for all the costs of the merger. The costs of the mergers were considerable, for example costs for new buildings and more personnel.

Both mergers disturbed the personnel's expectations of the organization, and part of the personnel of both hospitals met the merger with a negative reaction. There was more protest and opposition against the merger in the Swedish case than in the Icelandic case. In both mergers some personnel left the hospital for good because of the merger. In the SU, personnel left as an active protest, but in the LSH, physicians left for economic reasons starting their own clinics. In both mergers, the personnel complained about a higher workload, decreased relationship with managers, less communication in the organization, less opportunity for initiative at work, less discussion about working relationships, and more emphasis on budget and keeping the budget in balance. The path from the personnel to the director became longer in both cases. The personnel turnover increased in both hospitals and the personnel had problems in adjusting to the new organization and identifying with it. The managers of both hospitals had been too busy in the merging process, which resulted in the other managerial issues suffering negligence.

There were three main criteria for successful mergers mentioned in the theoretical background. The first is a clear goal of the merger. Both of the mergers studied had unclear goals about what they were supposed to accomplish. The second is appointing the director of the new organization as early as possible. Both mergers fulfil this criterion, but it must be mentioned that in the Swedish merger it took too much time to appoint the other members of the management team, which was a clear disadvantage. The third criterion is to have a good communication system. There were however operational difficulties in the communication system in both mergers.

The mergers had different effects on quality of the hospitals in the study. In the Swedish merger, there were signs of a decreasing quality of care in the hospital after the merger. It is very difficult to assess the quality of care, since it involves client quality as well as

a professional quality. It may also involve management quality. Even if it is difficult to establish a decreasing quality of care, it is quite clear that there was not an increasing quality of care. In the Icelandic case, the quality of care seems to be increased by the merger. The client quality improved in the way that the hospital performed a greater number of operations and also operations which had not been done in the hospital. It is difficult to measure if the professional quality improved or not. The professionals say that the new hospital is capable of serving its patients in a better way and the merger will strengthen the hospital's role as a university hospital. They also say that after the merger there is more workload. The managerial quality improved in a way that the hospital was capable of operating without a deficit.

There is a great difference in the outcomes of the mergers. The study looked at the first three years of the operation of the new hospitals. The Swedish merger did not have the expected results; it had rather negative results that resulted in a restructuring of the SU in 2001. The first three years of operation were extremely chaotic in SU. The hospital was supposed to save over 500 million SEK in operational cost, but instead there was a budget deficit of over one billion SEK. There was no stability in the management and the personnel were disappointed with the situation. The new structure of divisions and the new clinical structure in the hospital were not working. After three years of operation, it was therefore decided to abandon the divisional structure and to restructure the SU hospital into an area based hospital.

The Icelandic case was different. The management team was able to halt the increase of costs, even though the operating costs have increased (in line with the price index). The number of personnel and beds has decreased. The hospital has become a larger professional unit, which has strengthened the scientific work of the hospital. The merger process is not finished in the Icelandic case, because the hospitals will relocate to one area and this work has just started. The other buildings are being closed down, and the services are being moved to the new area. The aim of decreasing duplicated work has been successful in the LSH.

In general, more outcomes are positive in the Icelandic merger than the Swedish one. The Icelandic merger came much closer to fulfilling its aims than the Swedish one. Having said this, it must be underlined that the Swedish merger was much better prepared than the Icelandic case.

The demand for savings of 500 million SEK damaged the Swedish merger considerably and probably made the director and the management team too occupied with economic factors, instead of leading and strengthening a new organization. The demand for savings came late, after the personnel had given their approval for the merger. Therefore, it can be said that much of the preparation work was useless, because the demands for savings changed everything for the new organization. The Icelandic case was much more modest in the demands for savings.

There is a fundamental difference between Sweden and Iceland regarding health care. In Sweden, the county councils and the municipalities are responsible for the health services, but in Iceland the state is responsible. The SU is Sweden's largest hospital, but there are other large hospitals in Sweden, for example in Stockholm, Lund and Uppsala. In Iceland, LSH is the biggest organization in the country, and there is no similar hospital operating there. In fact, LSH is nine times bigger than the second largest hospital in Iceland, measured by the budget. Therefore, the LSH is a more unique hospital than the SU, and LSH has a monopoly on how much health services can be available, unlike Sweden, where SU has to compete with other hospitals.

7. Conclusion

It has become increasingly common, both in Iceland and in Sweden, to merge organizations in order to create a bigger and more effective organization. Those who are in favour of such mergers often refer to the synergy effect to justify the merger. Merging organizations is however a delicate matter. It must be done in a professional way and the timing is extremely important. There are no simple recipes available regarding the right time to merge. Those who are on the way to implement a merger must have the judgment to decide when. If organizations are merged in an unprofessional way, it can lead to incredible problems for the new organization, such as a poor communication structure, a poor management of the organization, and qualified personnel leaving the organization for good. It can also result in costs of merging the organizations far greater than the possible gains of the merger. The Swedish case shows that the demand for efficiency has its limits.

The decision to merge public organizations is usually made by politicians, who delegate the implementation process to administrators. The mergers studied show that the merging process was carried out without proper investment in time and effort to inform the personnel about the goal of the merger. That can lead to difficulties when the new organization starts to operate. When problems arise in the merging process, the politicians may say that they are not responsible and blame the administrators for poor handling of things. The administrators, on the other hand, may be trying to implement the merger without proper resources to inform and explain the merger to personnel. If the implementation of a merger is done without the support of the personnel, things can go badly for the newly merged organization, as the Swedish case showed.

The study has shown that the process of merging public organizations is something that must be planned adequately. It is necessary to prepare mergers in order to make them successful. There are a number of questions that must be answered in such a preparation. What exactly is the merged organization supposed to accomplish? Is the new organization supposed to cost less money? Is the merger supposed to solve structural

problems in the former organizations? When these questions have been analyzed, the answers must be used to give the personnel in the new organization necessary information, so they can understand the need for the merger. Those who decide to change organizations with mergers must be aware that both the preparation for the merger and the provision of necessary information to the personnel cost money. There were good preparations in the Swedish case, but not in the Icelandic case. However, the strange thing is that the Icelandic case was closer to its goals than the Swedish one.

8. References

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