Management and reforms in the Nordic hospital landscape

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Introduction

The Nordic countries are small, pluralistic democracies and are frequently considered to be a distinct group in political science studies (Knutsen, 2017). This article asks if the Nordic distinctiveness also includes ideas about management in hospitals. We try to find some answers by using the results from the academic literature in the field.

All Nordic countries have, over the last few decades, engaged in several hospital reforms. Comparative research points to some distinctive national variants in the way Nordic health care reforms have been introduced (Magnussen et al., 2009). These variations, in turn, may have consequences for how managerial roles connect and evolve within different national health systems. However, there are reasons for expecting similarities rather than variations. First, the strong position of professionals and their understanding of management could be a more powerful explanation for the variables than reform variations. Second, the influence of new public management (NPM) in the Nordic context, may have introduced similar expectations of managerial roles in hospitals.

The overall objective of this article is to explore how academic literature – in a reform context - has dealt with hospital management and management roles. Through a literature review, we explore differences and similarities in how managerial roles are perceived and linked to reforms in the Nordic hospital landscape.

We emphasize the following questions:

1. Which perspectives on management are present in the literature, and do these perspectives differ between the Nordic countries and reform variations?
2. In the literature, is it possible to identify certain connections between reforms and Nordic manager roles within hospitals?

The remainder of this article is organized as follows. The next section presents some perspectives on management and management roles, followed by a description of major

changes and reforms in the Nordic countries (2000 – 2016). Then, the methodology and results sections follow, and we finish with a conclusion and suggestion for further research.

Different perspectives on management in hospitals

Management is not an easy concept to define. It has a widespread currency and connections to other concepts, like leadership. In this article we want to explore how management and management roles in hospitals are described and understood in the academic literature. Our design is abductive (Alvesson and Sköldberg, 1994) in that we start out with some broad and tentative theoretical dimensions which we assume could be relevant in classifying perspectives represented in the literature. These dimensions are: Management – Leadership; Manager's role and position; Management – Professionals.

Management - Leadership

Some writers, like Kotter (1990), argue that there is a difference between management and leadership with regard to orientation to change. Management is concerned with the here and now; it is the process of communicating, coordinating and accomplishing actions in the pursuit of objectives (Clegg et al., 2016). Leadership, by contrast, is concerned with broader questions about organizational identity and purpose. Leadership thus draws attention to the active promotion of values, while management is more about getting the job done (Bryman, 1996).

We ask how the academic literature on hospital management, in a reform context, uses the management concept. Does the literature distinguish between management and leadership, or are the two concepts seen as complementary, describing various aspects of being in charge?

Manager's role and position in the hierarchy

The concept of manager is ambiguous and normally covers both the person that has a formal role or function within an organization (i.e. hospitals) and the activities that a manager carries out (Lund Martinsen, 2015). In addition, there are differences within the management hierarchy. Typically, first-level or front-line managers (lowest level in the hierarchy) have no levels of management below them, second- or mid-level managers have at least one level of management above them, and third- or upper-level managers are at the highest-level in the hierarchy of the organization.

When we use the role concept as it relates to the manager concept, we are especially interested in the expectations that apply to manager roles in the academic literature. The word role is used mainly to refer to typical expectations (Calhoun, 2002). Strain may arise when two or more roles associated with one status are in tension (role conflict).

Management - Professionals

Hospitals have been described as professional bureaucracies dominated by professionals who value autonomy (Mintzberg, 1979). The medical profession has traditionally been on the top of the professional hierarchy (Freidson, 1970), and questions of management and management roles include potential conflicts with professionals and their control over the knowledge system. Mintzberg (2012) points out that there could be interesting differences between professions on this matter: nurses, who focus on care, could be a more appropriate model for managing, than doctors, who focus on cure.

We ask if and how the academic literature reflects on the encounter between management and professionals in hospitals, and pay special attention to possible differentiations' between nurses and doctors.

Nordic hospital reforms and major changes

Reforms inspired by NPM have swept through most European countries since the 1980s and have influenced government thinking to this day (Hammerschmid et al., 2016). Such reforms are typically implemented to improve efficiency and accountability and have argued for introducing business management logic into the public sector. Empirically, NPM has been associated with different interventions and reform intensities (Pollitt and Bouckaert, 2004). Some authors declare that we have now entered a post-NPM era, dominated by governance and network-style approaches (Van de Walle et al., 2016). In a hospital context, we expect that NPM and post-NPM paradigms will be reflected both in different reforms and in the way changes are presented and interpreted in the academic literature.

An important basis for national health care reforms are rooted in major economic challenges, due to the increasing cost of medical technology, rising patients' expectations and a rapidly ageing population. All of these strain resources, and countries affected may use several reform instruments to achieve change. This change is often a dismissal of the status quo that reform advocates see as an improvement (Cain, 2001). Here we define reforms and major changes in

the Nordic hospital landscape as processes where states make changes that involve various degrees of intervention of institutionalized practices in hospitals. Such processes may lead to changes in laws, regulations, institutions, practices and managerial roles. The purpose of reforms may address various problems. Reforms can be relatively complex and conflictual, especially if they lead to changes of a greater economic, political or legal nature.

Sweden, Norway, Denmark and Finland have specialist health care services based on the same principles and with much the same structure: universal access, predominance of tax-financed public provision, and different levels of public administration in charge of primary and secondary health care (Magnussen et al., 2009). Below, we provide some insight about differences and similarities in major changes and reforms one would assume would affect managerial roles and management in the four countries.

Norway

During the 1980s, reforms in Norway were aimed at achieving cost containment and decentralizing health care services. In the following decade, the focus was on efficiency. From about 2000, Norwegian health authorities focused on structural changes and policies intended to empower patients and users. The 2002 reforms shifted responsibility for specialist care away from the counties (Magnussen et al., 2009). Nowadays, responsibility for hospitals lies with the state – The Ministry of Health – and is administered by four Regional Health Authorities. The municipalities are responsible for primary care. After 2010, policy efforts have sought to improve coordination between health care providers (Norwegian Ministry of Health and Care, 2009), as well as increase attention to quality of care and patient safety issues (Ringard et al., 2013).

Finland

The aim of Finnish health policy has been to reduce hospital and other kinds of institutionalized care and to expand outpatient and home care services. The growing number of older persons, together with pressure for cost containment, has also influenced this emphasis on outpatient care. The majority of Finnish health care services are organized and provided by the municipal health care system. Specialist care in the municipal system is provided by hospital districts, each of which is owned and funded by its member

municipalities. Each hospital district has one or several hospitals, one of which is a central hospital (The Ministry of Social Affairs and Health, 2017). According to Vuorenkoski (2008), there was no major reform of the health care system in Finland between 1997 and 2007. Still, there have been a number of changes addressing specific issues: in 2001, the government initiated the National Project to Ensure the Future of Health Care. The project focused on improvement in efficiency and productivity; the need for an increased labor force; improvement of working conditions and improved continuous medical education; health care financing; improvement of steering mechanisms; cooperation between public health care, private health care and NGOs; and the consolidation of treatment practices and improvement of access to treatment (Vuorenkoski, 2008). In 2005, a national health care guarantee was introduced into Finnish law. The guarantee defines maximum waiting times for hospital and primary care services, including dental care (Jonsson et al., 2013).

Sweden

Services for conditions requiring hospital treatment in Sweden are provided at county and regional hospitals. The county councils own the majority of hospitals. One important aim behind the structural changes in Swedish health care since the 1990s has been a shift from hospital inpatient care towards outpatient care at hospitals and primary care facilities (OECD, 2013c). Health care reforms in the period 2000 – 2016 relate to concentrating hospital services; regionalizing health care services, including mergers; improving coordinated care; increasing user choice, competition and privatization in primary care; privatization and competition in the pharmacy sector; changing co-payments; and increasing attention to public comparison of quality and efficiency indicators, the value of investments in health care, and responsiveness to patients' needs (Anell et al., 2012).

Denmark

Denmark's five regional governments are the owners and operators of public hospitals, which tend to provide the bulk of secondary and tertiary care for the country (OECD, 2013a). In the 1990s Denmark introduced a number of reforms oriented towards questions of efficiency and targeted at reducing waiting times (ibid.). Health care reforms in the period 2000 – 2016 relate to hospital reimbursement through Diagnosis Related Groups (DRGs), introduction of waiting time guarantees, restructuring the hospital sector into fewer hospitals (to promote specialization of the most complex hospital services), provide municipalities with incentives

to make efforts to reduce hospitalizations, quality safety programs, and strengthening patients' involvement (OECD, 2013a, Christiansen, 2012).

Although similarities exist between the Nordic countries with respect to the direction and the content of major changes or reforms in the hospital sector, there are still differences between the countries. According to Magnussen et al. (2009) there are differences in timing and policy solutions. Typical for Norway and Denmark, major changes or reforms in the sector are mainly implemented through central initiatives. The structural reform in 2007 (Denmark) and the hospital reform in 2002 (Norway) are examples of central state reform initiatives. Sweden, and particularly Finland, tend to be characterized by substantially more power at the decentralized levels of governance structure when it comes to reform design and implementation (ibid.). Important here are differences in the organizational structure of national health services, with hospital administration being significantly more decentralized (at county and municipal levels) in Denmark (Vrangbæk and Christiansen, 2005). Still, when it comes to tendencies that are linked to major changes in the hospital sector, we see more parallels then substantial differences. These tendencies can be linked to NPM and general globalization trends, which can be interpreted as adjustments to regional structure and development in the EU (Magnussen et al., 2009).

Summing up, the following trends are relatively similar in all four countries and might affect managerial roles, although the pace, timing and scope vary. Changes in regulation, with the intention to strengthen patients' rights – e.g. patient choice and complaint procedures. All the Nordic countries have strengthened patients' rights, a process that started around the 1980s. This might affect managerial roles regarding adherence to patient involvement, reputation management and complaint handling. Another tendency is that evidence-based medicine has grown and is supported by OECD (OECD, 2005, OECD, 2013b, OECD, 2013a, OECD, 2014). This might affect the hospital managerial roles and management regarding adherence to quality systems, procedures and controls. This manager function refers to monitoring staff activities and performance and taking actions in corrective initiatives. The last tendency we recognize is the tendency to strengthen coordination of care between hospitals and municipal care, as described above. We assume that these ambitions might affect the hospital manager's role in networking, collaboration and partnership activities.

Methodology

We included only original articles published in English in journals with peer review between 2000 and 2016. Articles covering quantitative, qualitative or mixed methods design were included. We conducted a search in the Scopus database (www.scopus.com) and applicable journals: *BMC Health Services Research*, the *Journal of Health Organization and Management* and the *International Journal of Public Sector Management*.

We searched the article titles, abstracts and keywords. We entered the following search string for each country separately:

reform* OR change* AND hospital* AND manage* OR leader* AND Norway
reform* OR change* AND hospital* AND manage* OR leader* AND Sweden
reform* OR change* AND hospital* AND manage* OR leader* AND Finland
reform* OR change* AND hospital* AND manage* OR leader* AND Denmark

The search yielded a total of 180 hits (see table 1). After having scrutinized the search results, we excluded 162 articles, as they did not fulfil the inclusion criteria. The excluded articles did not emphasize changes in leadership/manager roles or management in light of hospital reforms or major changes or in the Nordic hospital landscape. We ended up with 18 articles.

[Table 1. Search results in Scopus and selected journals - period 2000 – 2016]

The final search results show that Norway has the highest number of publications (9), and the remaining countries have 2-4 publications each on the topic.

We accessed full-text versions of the 18 articles. The analysis followed a multiple step procedure: 1) the articles were first read by all authors, 2) all authors worked out categories based on what we wanted to know, 3) the articles were uploaded to Nvivo for further analyses, and 4) based on the coding of the content in the articles, first author made summaries which have been transferred to tables in the results section.

Results

Table 2 illustrates what kind of manager or management perspectives dominate, as revealed in the literature. Nine of the articles were typical theoretical contributions at a meta-level, not focusing on specific manager levels, but management as phenomena. Methodologically, many

of these studies were based on literature reviews. Six articles encompassed data about the mid-level manager's perspective on hospital reforms. Two articles cover the upper-level manager's perspective, and two other studies incorporated the front-line manager's viewpoint. Only one article covers the employee's perspective on management.

[Table 2. An overview of manager or management perspectives in the revealed literature]

There is a variety of different research designs used in the articles under consideration (see table 3). Six articles are contributions that build on the author's reflections and analysis, which again relies on secondary sources. There also examples where an author (or authors) used different mixed research designs (3 articles). The majority of the articles were based on qualitative methods.

[Table 3. An overview of chosen research design]

Table 4 gives an overview of who funded the research for the studies we examine. Twelve of eighteen articles were self-financed/undisclosed, meaning it was not possible to identify who funded the author(s) research. Some of these articles were part of doctoral studies. This violates the recommendations for research ethics. Three articles were financed through National Research Councils in Norway (2 articles) and Sweden (1 article).

[Table 4. Main source of funding]

As shown in Table 5, the vast majority of the Nordic articles are relatively coherent on the following: 1) the reforms or major changes have created a change in the manager role or rather there are new expectations about the content of the manager role. 2) The reforms entail tension between professionals and the administration. Doctors who are managers identify themselves primarily as doctors, implying that their medical logic has not been overtaken by an administrative logic. 3) The reforms have brought new opportunities for nurses. Still, nurse managers perceive tension between the profession and administration. 4) NPM is often the framework or background for understanding change in hospitals or manager roles in the articles. 5) The majority of the articles focus on management as a general key concept. Leadership, in line with Kotter (1990), is not a central issue in the articles.

Most of the Norwegian articles discuss implications of the Norwegian hospital reform in 2002 or the introduction of unitary management (Aasland and Førde, 2008; Berg and Byrkjeflot, 2014; Mo, 2008; Pettersen and Nyland, 2006; Pettersen and Solstad, 2015; Spehar and Kjekshus, 2012a; Johansen and Gjerberg, 2009; Martinussen and Magnussen, 2011).

Theoretical perspectives in the majority of the 18 articles are mainly rooted in terms of NPM, often in combination with institutional theory or theories of profession or governance. Aspects of reforms are primarily treated as independent variables; for example, how the reform or change affects the professionals (nurses or doctors) or managers. The articles by Pettersen and co-authors (Pettersen and Nyland, 2006; Pettersen and Nyland, 2012; Pettersen and Solstad, 2015), are distinguished from the other contributions through a focus on the implementation of different management control instruments.

[Table 5. Perspectives and findings in the revealed literature]

Discussion

At the beginning of the article, we outlined three dimensions for classifying different perspectives on management in hospitals: Management – Leadership, Management – Professionals, and Manager's role and position. In the following, we seek to address and discuss our findings in light of these dimensions in relation to our research questions.

Management - Leadership

Most of the included articles use the concepts of management and manager. Reasons for this may be the strong emphasis on how NPM elements in the reforms and major changes have affected the management/leadership role. The tension between management and professionals that is shown in the literature also implies that management, in contrast to the medical/clinical professionals, is about getting the job done. The fact that many of the articles look at management from a general perspective (Table 2) could also be a reason why management, instead of leadership, is used.

Only four articles actively use the concept of leadership. Sørensen et al. (2011) analyze nurses in leadership roles and make a distinction between clinical leadership and managerial leadership. This distinction is based on whether nurses give priority to clinical work or management and daily operations. Johansen and Gjerberg (2009) make a similar distinction and show that doctors and nurses reflect differently on their roles as unitary managers. For doctors their professional identity was a fundamental part of being managers, and they therefore saw the manager role as clinical leadership. The opposite was true for the nurses; they primarily understood leadership as management. Konu and Viitanen (2008) refer to management as a role in an organization, while leadership refers to the way this role is executed. Managers are in charge but do not necessarily apply leadership. Shared leadership, which is the main focus in the study, is closely connected to values of collectiveness, decentralization and empowerment. Pedersen and Hartley (2008) take a more general approach and describe how reforms and major changes in the public sector offer a dynamic image of the concept of leadership and management itself. Management is seen as insufficient on its own to address the demands of a large scale and rapid reform agenda. However, leadership has become the new mantra and buzzword, and managers must continue to provide ever improving high quality and reliable services while also dismantling and reconfiguring these same services.

Management – Professionals

Eleven articles focused on the relationship between management and professionals. Six of them have an explicit interest in how medical doctors reflect on and engage in the encounter between management and professionals (Kuhlmann et al., 2016; Opdahl Mo, 2008; Spehar and Kjekshus, 2012b; Kirkpatrick et al., 2009; von Knorring et al., 2010; Martinussen and Magnussen, 2011). They all show that doctors emphasize their professional values over management values. We see examples of arguments about doctors being more difficult to control (von Knorring et al., 2010) and less effective in reaching reform goals (Kuhlmann et al., 2016). In spite of this, Kirkpatrick et al. (2009) argue that a strong model of professionalism, that is central in all Nordic countries, causes a stronger commitment and involvement by the doctors in management roles and reform implantations than in the UK. This also allows doctors to imbue the manager role with more professional values. This hybridization is also recognized by Opdahl Mo (2008), but Martinussen and Magnussen (2011) challenge the notion of hybridization and show that there is a heterogeneity in how doctors deal with the new manager role. Some doctor-managers adopt management values, whereas others remain alienated from them. Kjekshus et al. (2013) point out that Norwegian doctors have seemingly lost some of their previous dominance in hospital management, but they have gained a more influential position in formal decisions.

Two articles look at how nurses reflect on and engage in the encounter between management and professionals (Sørensen et al., 2011; Blomgren, 2003). Both articles have a weak connection to reform and focus more generally on how nurses have encountered the NPM effect on hospital management. Both emphasize that nurses must handle the conflicting values between management and professionals. Blomgren (2003) points out that the new management role has strengthened nurses' power in the hospitals but weakened their role as experts in care. Sørensen et al. (2011) show how nurses handle the tension between nursing and management by taking one of three different roles: the clinician's, the manager's or a hybrid role.

Three articles compare how doctors and nurses reflect on and engage in the encounter between management and professionals. (Johansen and Gjerberg, 2009) raise this question in connection with the implementation of unitary management, while Berg and Byrkjeflot (2014) and Kirkpatrick et al. (2011) take a more general reform approach. Doctors see the

manager role as something temporary, but for nurses it is more of a career track (Johansen and Gjerberg, 2009; Berg and Byrkjeflot, 2014). In this regard Kirkpatrick et al. (2011) point out that the NPM reforms have challenged the professional boarders and power relations in hospitals.

Five articles have a Norwegian context when discussing the tension between management and professionals, four have a Danish context and three have a Swedish context. There were no clear differences between these countries.

The articles show a pretty uniform picture of how professionals reflect on and have encountered major changes in management reforms. The theoretical perspectives that are most frequently used in the literature, profession theory and institutional theory, highlight tensions between management and professionals. The weak connection to the reforms and a more general perspective of NPM in many of the articles also emphasizes these tensions. A problem with such an approach is that it concentrates on just a small part of the reform context. Other reform areas – e.g. patient or user involvement and complaint management, reputation management, networking, coordination and control – are difficult to identify in this part of the academic literature. Another issue is that reform and major changes in this part of the literature are seen as independent variables. Thereby the focus is directed toward how the professions succeed or fail in producing a new "gold standard" of management.

Manager's role and position

Our findings confirm relatively coherent perspectives and tendencies on management or manager roles related to hospital reforms in the Nordic countries. Empirical data, typically from mid-level managers (see Table 2), supported the health profession perspective. Within that perspective, there seems to have been fewer changes for managers who have a professional background, so fewer for doctors than nurses. Several contributions propose that managers with a professional background, especially doctors, are still more devoted to the profession than management. This might have consequences for the success of hospital reforms or major changes, since managers are vital to meeting the goals that underlie the changes.

Another dominant perspective on the manager's role was the general management perspective. Articles within that category were typically macro- or meta-level oriented. The most preferred research design within this category was literature review (see Table 3).

Reflections

In a more fundamental way, our initial research questions gave us an opportunity to explore and reflect upon the academic literature per se. To what degree is research generic and international in that reforms and management are treated with some degree of conceptual equivalence? Alternatively, is there interdependence between the authors and chosen their perspectives? The fact that we found relatively coherent perspectives may be due to several factors. Researchers often travel to the same conferences, participate in the same research projects and read each other's texts. This may imply that perspectives on management and hospital reforms are more or less "frozen". The fact that the development of concepts and perspectives within the academic world itself is the result of strong institutionalization in research environments, has similarities with what Thomas Kuhn (1996) describes as a normal scientific paradigm. Normal science is an attempt to arrange, and if necessary push, a specific understanding into the paradigm's form. If empirical findings prove to be inconsistent with theory, one will often try out new theory. However, this can't be done within normal science, but only through crisis (Kuhn, 1996). To illustrate likely influences between the aforementioned issues within the framework of our study, we give a concrete example within the chosen research field.

The year 2009 was the start of the European Cost Action Program *Enhancing the role of medicine in the management of European health systems - implications for control, innovation and user voice* (see http://www.cost.eu/COST_Actions/isch/medicine_in_european_health_systems). The main objective of this Action Program was to increase empirical, theoretical and policy relevant knowledge about the changing role of medical professionals in the management of healthcare. Professor Ian Kirkpatrick (UK) was the chair of the Action Program. Members of the management committee also included former PhD-students in the Action Program. Some of these PhD-students' research is among the articles listed in Table 5. Links between some of the Nordic participants in the Action Program are also visible when looking at how these participants refer to each other's work.

The aforementioned example is a natural part of belonging to an academic family and sharing similar research interests. The possible danger, however, is that mindsets within that family may be reproduced (groupthink), and that given conceptions and perspectives are not challenged. On the other side, without European programs like Cost Action we might not

have knowledge of reforms and the impact on management and manager roles in the Nordic countries.

Strengths and limitations

We limited our search to the period 2000 – 2016 and have only included articles published in English. There are several limitations to these choices: 1) we may have missed research published in a language other than English (i.e. Norwegian, Swedish, Finnish or Danish). 2) It may take years before consequences of hospital reforms have impact on management and manager roles. Some of the articles were published relatively shortly after the implementation of the reform. 3) Many factors of reform have an impact on management or manager roles, thus it is challenging to give simple explanations.

Future research

The authors of this review did not explore whether the similar perspectives and connections between reforms or major changes in hospitals and management that we found in our research is also dominant for countries outside the Nordic region and Europe. Does the same perspective prevail in countries where private health providers are more dominant compared to the Nordic countries? Future research should explore this trail.

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Table 1. Search results in Scopus and selected journals - period 2000 – 2016

	NO*	DE	SE	FI	Total
Article hits after first search	55	36	69	20	180
Articles excluded	46	32	66	18	162
Articles included	9	4	3	2	18

*NO= Norway, DE= Denmark, SE= Sweden and FI= Finland

Table 2. An overview of manager or management perspectives in the revealed literature

	NO	DE	SE	FI	Total
Manager hierarchy not clearly defined, management as general phenomena	3	3	2	1	9
Mid-level manager's perspective	4	1	-	1	6
Employee perspective on management	1	-	-	-	1
Upper-level manager's perspective	1	-	1	-	2
Front-line manager's perspective	-	1	-	-	1
Sum	9	5*	3	2	19

*The Danish article by Sorensen, Delmar and Pedersen (2011) incorporates empirical data from nurse managers at different levels in the hospital organization. Thus, the number of perspectives covered in Danish articles exceed the number for Denmark, see table 1.

Table 3. An overview of chosen research design

	Number of articles
Literature review	6 articles
Mixed design	3 articles
Survey	3 articles
Interviews	3 articles
Document analysis	2 articles
Ethnographic study	1 article

Table 4. Main source of funding

	NO	DE	SE	FI	Total
Self-financed/undisclosed*	6	4	1	1	12
National Research Council	2	-	1	-	3
Profession (i.e. Medical or Nurse Association)	1	-	-	-	1
Public fund	-	-	1	1	2
Sum	9	4	3	2	18

*Some of the articles were part of doctoral studies.

Table 5. Perspectives and findings in the revealed literature

Title	Perspectives and findings	Country
Unitary management, multiple practices? (Johansen and Gjerberg, 2009)	To explore whether unitary managers with different professional backgrounds carry out and reflect upon their role as unitary managers. Doctors and nurses in many respects perform their roles as unitary managers differently.	Norway
Reforms and clinical managers' responses: a study in Norwegian hospitals (Pettersen and Nyland, 2012)	To explore the legitimacy of management control processes in hospitals. Diversity in practices and quite wide decision space for clinical managers in hospital departments. There was not much change.	Norway
Doctors' professional right of voice (Aasland and Førde, 2008)	Hospital doctors' experiences regarding professional right of voice related to hospital reform. Doctor's professional right of voice is weakened. Leaders must improve dialogue with doctors.	Norway
Management and control of public hospitals – the use of performance measures in Norwegian hospitals. A case study (Pettersen and Nyland, 2006)	How do performance measures give relevant information for decision making in hospitals? No clear effect of reform or changes. There is little knowledge on the connection between activities in the hospital and the factors that drive costs.	Norway
Vertical and horizontal control dilemmas in public hospitals (Pettersen and Solstad, 2015)	The aim of the study is to analyse how managers at different levels in the local hospitals manage the horizontal and vertical control challenges. Vertical lines of the management control system have been implemented, but not so much the horizontal control system. The two systems, the administrative and the professional system, coexist at the operational level but without being interlinked by the top managers.	Norway
Doctors as managers: moving towards general management? (Mo, 2008)	Does the development in department management constitute changes of concepts and practices that step away from the profession-based manager in the direction of a general manager-model? NPM-inspired managerial ideas seem to influence managerial practice. Still, the profession seems to dominate at the department level. The reform is not able to get past the institutionalized logic of professional knowledge.	Norway
Resisting market-inspired reform in health care: the role of professional subcultures in medicine (Martinussen and Magnussen, 2011)	Investigated how doctors perceive the reform's overall impact on the hospitals and whether they believe that the reform has led to more equal access to health services, better medical quality, and increased hospital productivity. Doctors with managerial responsibilities were more positive in their evaluations of the reform. Doctors who spent time on direct patient-related work showed the opposite pattern. Medical professionals' adaptation to the new institutional logics of the health care sector is more accurately characterized by polarization than hybridization. Doctor's reactions to the reforms have been heterogeneous.	Norway

Title	Perspectives and findings	Country
Management in hospitals – a career track and a career trap. A comparison of physician and nurses in Norway (Berg and Byrkjeflot, 2014)	Explore how reforms have affected doctors and nurses in management, related to management roles at different levels in hospitals. Doctors interpret general management in a way that indicates hybridization of management. Among physicians, professional work is still more valued than management. For nurses, the expanded focus in management seems to be in accordance with their traditional view of management, and the unitary management positions are viewed as a new career track.	Norway
Medical Management in Norwegian Hospitals (Spehar and Kjekshus, 2012)	Investigates how doctors engage in hospital management. Norwegian doctors have seemingly lost some of their previous dominance in hospital management, as other professions have entered traditional areas of medical influence. However, we argue that doctors appear to regain an influential position in formal decision making by entering positions with higher potential for influence.	Norway
The changing context of public leadership and management – implications for roles and dynamics (Pedersen and Hartley, 2008)	Examines the central modernizations and improvement themes of public service reform in Denmark and the UK. Managers cannot rely on a fixed legal or professional set of values but must be able to decode, challenge and develop varied sets of values and goals, working with varied rationales for action. Management and leadership positions are partly created through negotiated relations in a network-like governance structure.	Denmark
The contested terrain of hospital management: professional projects and health care reform in Denmark (Kirkpatrick et al., 2011)	Focus on the experience of the Danish hospital system with health management reforms. The balance of power between clinical professions (nurses vs. doctors) has changed. Doctors are further strengthening their position largely at the expense of nurses.	Denmark
Leading nurses in dire straits: head nurses' navigation between nursing and leadership roles (Sørensen et al., 2011)	Investigation of hospital head nurses' leadership practice in order to uncover their negotiation of the role between nursing and leadership. At the first-line level, leadership practices were characterized by an inherent conflict between closeness and distance to clinical practice; at the department level, practices were characterized by recognition games. On both levels, three interactive roles were identified, that of clinician, manager and a hybrid role.	Denmark
Medicine and management in a comparative perspective: the case of Denmark and England (Kirkpatrick et al., 2009)	Focusing on the experiences of new public management (NPM) reforms in the acute hospital sector in two north European countries: Denmark and England. Hybrid clinical management roles have advanced and are more strongly supported by the medical profession in Denmark, compared to England. In some contexts (Denmark) change has been introduced in ways that increase the opportunity for doctors to colonise management roles.	Denmark
Managers' perceptions of the manager role in relation to physicians: a qualitative interview study of the top managers in Swedish health care (von Knorring et al., 2010)	Seeks to understand how top executives in Swedish healthcare regard management of physicians in their organisations, and what this implies for the manager role in relation to the medical profession. Results indicate a strong medical profession and CEOs often tend to focus and rely on the doctor's role, rather than the manager role.	Sweden

Title	Perspectives and findings	Country
Medicine and management: looking inside the box of changing hospital governance (Kuhlmann et al., 2016)	The study aims to explore the organizational needs of doctors using Sweden as a case study. Health policy has strengthened the demand for coordination between clinicians and managers. New tasks and roles have emerged. Medical managers do not primarily define themselves as managers and part of an organizational system. Integrated modes of hospital governance on the marco- and meso-levels, do not easily impact further down on the micro-level in ways that create efficient organizational responses to the needs of doctors.	Sweden
Ordering a profession: Swedish nurses encounter new public management reforms (Blomgren, 2003)	This article addresses the question of professional responses to, and handling of, New Public Management reforms in the context of Swedish health care. NPM aligned more easily with the process of ordering nurses into administrative leaders than with the process of ordering nurses into experts in caring. The nursing profession supported the idea of delegation of financial responsibility, because of the expectation that this would strengthen the head nurses' positions in relation to the physicians.	Sweden
Shared leadership in Finnish social and health care (Konu and Viitanen, 2008)	Investigates the occurrence of shared leadership among middle level managers in social service and health care. No links to reforms or major changes, but shared leadership practices were more common among managers other than those with medical background.	Finland
Health care management in Finland – an analysis of the wickedness of selected reforms (Vartiainen, 2008)	Describes wicked problems in Finnish health care management reforms. The context of health care management is more multi-dimensional than the solutions and reforms created to solve the problems that management have acknowledged. Management reforms succeeded only partly.	Finland