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MANAGEMENT VALUES, RESOURCES AND POWER

A comparison of Management Values in Ålesund and Vaasa Hospitals

Master's Thesis in
Public Administration

VAASA 2009

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Master Thesis: Management Values, Resources and Power: A comparison of Management Values in Ålesund and Vaasa Hospitals
Degree: Master of Administrative Sciences
Major Subject: Public Administration
Year of Graduation: 2009 **Number of Pages:** 84

ABSTRACT:

There are many papers out on the efficiency of Finnish public hospital system and there are several news stories in Norway about this. However I have yet to see one focusing on management values in Finland compared to other public hospital systems. In this thesis two hospitals will be focused on, one in each country. Furthermore it will look at these values and how these two hospitals compare to each other. First focusing on what are the differences and similarities in the softness and hardness of managerial values, and secondly is it possible to link this difference in managerial values to the management of Ålesund and Vaasa hospital?

The theoretical framework is based on Hofstede's MAS index, McGregor's theory X and Y and managerial powers which are used to convey orders and to which extent the employees share their managers' opinions about themselves and the system. This is done through interviews as well as questionnaires in a triangulation to find where these countries fall on a scale of hard to soft values. Both the empirical data and statistical data have been collected by thesis writer.

This study shows that there are softer values in Norway, but not as much as one would have expected by looking at Hofstede's MAS index. There are indications that the structure of the system is flatter in Norway as well. The managerial powers which are in effect also differ, but only slightly showing that there is some sort of structure in place limiting the use of certain powers. Finally this study finds that the level of work satisfaction is higher in Norway, and that lack of resources plagues both sides, in different ways, personnel in Finland and money in Norway. That Finland's health care system is more efficient than the Norwegian is true, but it seems to come at the cost of work satisfaction and recruitment of personnel.

KEYWORDS: Health care, Welfare state, Managerial Powers, Hospital Value Management, masculinity index, Theory X and Y

1. INTRODUCTION

“The view [Values:] of a man as a symbolizing, conceptualizing, meaning-seeking animal, which has become increasingly popular in the social sciences and in philosophy over the past several years, opens up a whole new approach not only to analysis of religion as such, but the understanding of the relations between religion and values.”(Geertz 2000: 140.)

In the above quote Geertz draws a connection between values and religion. The line he here makes can also be interpreted as culture (Culture is the common belief system and symbol system which people in a group or society has (Eriksen 1998: 23)) equals values, since religion is an intricate part of culture and especially the norms and values which each religion values. This connection between culture and values is obvious, but the line between culture and value is almost none existing. A culture and its values are a symbiotic entity which cannot be distinguished between in the sense that culture is that way because of the values, or vice versa. Thus leading to the more vague images of “desirable” values and outcomes and “desired” values and outcomes, which would be easiest described as a “fight” between ideologies and the ego. Ego is here the wants of the person, which way he would like to see himself, while the ideologies is the values which the culture highly regards, who will be declared the victor of these two sides might not be clear (Hofstede 1997: 8–11).

1.1. Purpose and overall aims

This thesis focuses on describing and testing management values in a Norwegian and a Finnish hospital. The idea to compare «values» between Finland's National Health Service (NHS) and Norway's NHS derives from Hofstede's book (2001) “*Culture Consequences*”.

1.2. Main research question

The purpose and aim in chapter 1.1. leads to the following two main research questions:

- *To what extent are Norwegian and Finnish hospitals different in relations to the hardness and softness of managerial values?*

- *Is this possible difference in managerial values affecting the management of Ålesund and Vaasa hospital and in if, in what way?*

1.3. Assumptions and delimitations

In this thesis there will be no mapping of culture as a whole, the main focus will rather be leadership, and rather the values found in leadership between two countries. The values themselves will be divided into hard and soft values. Where values will be defined as the ideas and symbols found in society, organizations or families about what are good, bad, desirable or beautiful, concepts of what goals are to be reached (Geertz 2000: 131; Kearns 2005: 2–3; George & Gareth 2006: 694). Values as such can be divided into hard values which are values which are objective, they often contain numbers, and consider outcome of the process rather than consequences during the process. Hard values are often described as masculine values, because of the stereotype of men as being objective and soft values which are subjective, and focus on the social part of the process. These values include none quantifiable values, like customer satisfaction (even if it is semi-quantifiable, it is still based on subjective perceptions, and is culturally relative). This would be also called the feminine side, since it falls into the stereotypical category of women as more subjective and less rational than men. (Nymark 2000.)

The figures which are used throughout this thesis are mostly gathered from World Health Organization (2008) and the numbers used are therefore collected and interpreted in the same system, and are reliable in that they use the same measurement. There is no intention of making this a thesis about only structural change since this

would be a mistake. Structural change can in best cases only give a partial explanation on how the health care sectors of different countries (or a single country) changes over time. Studies show that what is anticipated by doing certain structural changes does not give the improvements to quality and in efficiency which are expected. I therefore use an anthropological perspective which focuses on culture, and rather national culture than organizational culture alone. Studies show that the greatest influence on a manager is not the sector culture, organizational culture or industrial culture but rather national culture which means that it is the primary and secondary socialization which sets the “road map” for an individual’s behavior. (Berger & Luckmann 1991; Pizam, Pine, Mok & Shin 1997; Scott, Mannion, Davies & Marshall 2003; Byrne & Bradley 2007.)

By limiting the scope of research to employees from two hospitals, one in Finland and one in Norway the research could be conducted within an acceptable time. The triangulation approach conducted using both interviews and survey was feasible and accomplish able.

There are many threats to external validity that causes the results of a study to be specific to some limited group of people and/or set of conditions. This threats are those dealing with generalization to populations (what population can be expected to behave in the same way as this sample) and those dealing with «environment» of the study (under what setting and condition can the same results be expected).

1.4. Main theories and methodology used

The subject of difference within managerial values derives from Hofstede's (2001) book “*Culture Consequences*” and the differences in efficiency between Finland's National Health Service (NHS) and Norway's NHS could lie in values within the National Culture on the level of Masculinity / Femininity index. Using the five indexes of Power Distance, Uncertainty avoidance, Individualism / Collectivism, Masculinity / Femininity and Long-/Short-term orientation (see Appendix 6 for more detailed information). Hofstede's research only found significant difference within the Masculinity /

Femininity index between Norwegian IBM employees and Finnish IBM employees. I therefore find that the difference in efficiency between Norway's NHS and Finland's NHS is connected with the dominant values which exist within the leaders as well as workers within each countries NHS. According to Hofstede's (2001) index there will be softer values with a higher focus on qualitative measurements of efficiency in Norway, than in Finland. Another important theory here is McGregor's (1960; 1985) theory X and Y. This theory is used as a reference towards which of the extremes (X and Y) the different manager's countries lean. This benchmark will give a frame of reference in which managers from these two countries can be compared (McGregor 1985).

A third theory/frame of reference can be found in *Contemporary Management: Creating Value in Organizations* (George & Jones 2006) which contains the five managerial powers described as a function of relationships in the book *Bases of Social Power: Studies in Social Power* by social psychologists John French and Bertram Raven in 1959.

This thesis incorporates both quantitative and qualitative forms of gathering data. It uses quantitative partial subject involved questionnaires as well as the qualitative partial subject involved interviews (Schein 1997: 29). The questionnaires will expose the values which are dominant within the hospital and to what extent they are so. The NHS models in each country have the same basis the "health care for all" ideology. This idea means that one should receive the best possible health care in the country for a "low" price, paid through taxes (Barr 2004: 8–12).

In an attempt to find the underlying values this thesis performs a triangulation with both qualitative and quantitative measurement. The interviews are done with department heads, while questionnaires are answered by the subordinates. The questions focus on their work, with no private questions (Appendix 2). The questions are quite subjective, since they mainly focus on attitudes and feelings about their work and managers, which are the ultimate within subjectivity.

Furthermore this thesis incorporates legislation in its context base and the rules which

they have to comply. The values will in turn affect how the leaders feel they should follow procedures and legislations. As explained in chapters 2.1. and 2.2. the main difference between the two systems in Norway and Finland are the levels of freedom for the municipal authorities, as well as for the staff of hospitals when having new procedures and legislations to follow.

The questionnaires are designed to find several aspects of the employee – manager relationship. The questions used for this questionnaire and aspects measured were: leadership style: consideration (Lucas, Parasuraman, Davis & Enis 1987), work satisfaction (Rich 1997), trust in manager (Rich 1997), reward power (Comer 1984), legitimate power (Brown, Lusch & Nicholson 1995), referent power (Brown, Lusch & Nicholson 1995), coercive power (Brown, Lusch & Nicholson 1995), expert power (Gaski 1986) and McGregor's theory X and Y (Kopelman, Prottas & Davis 2008). There were also questions about how they viewed time and money, these however were developed by myself. All questions have been set to a seven point system Likerts scale, from strongly disagree (1) to strongly agree (6). All questions except questions on age and education, position, length of employment, management, nationality and department has been set to a six point Likert scale.

1.5. Framework of analysis

Figure 1 shows a framework which is a simple model of the factors which this thesis uses to determine Hospital Management Values.

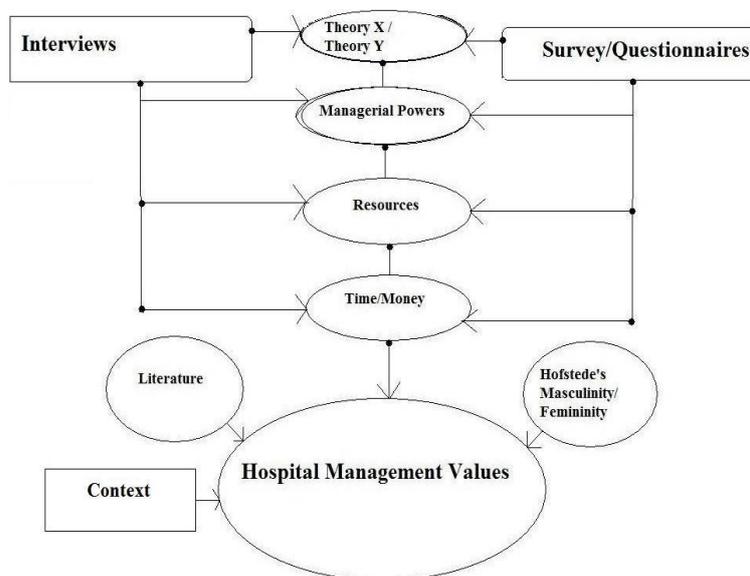


Figure 1. Framework of analysis

1.6. Structure of the thesis

Chapter one focuses on a short introduction containing information about the overall aims, framework of analysis (Figure 1), basic information about theories and methods used in this thesis. The second chapter incorporates the historical context of both Norway and Finland as well as aspects of the welfare state. Chapter 3 describes the theoretical framework and goes deeper into the literature on the subject, introducing theories and data. The most important of these theories being Hofstede (1997; 2001) IBM data collection and the five indexes in which masculinity/femininity index (MAS) is the most important. The chapter also includes McGregor's theory X and Y and the five managerial powers (George & Jones 2006) which as well as a 6th trait (leadership style consideration) which a manager should possess (Lucas, Parasuraman, Davis & Enis. 1987). The chapter also discusses how these managerial powers and theories fit together in the idea of hard and soft values. The resource situation at both hospitals and each nation are described. Chapter 4 describes the qualitative and quantitative methods

used for collection data. The fifth chapter will focus on statistical data collected as well as empirical data from the informants. The first part of this chapter focuses mainly on statistical data, the aspect of resources, the five managerial powers (Figure 4), trust in manager and work satisfaction as well discuss these findings. The second part goes deeper into the empirical data collected. The last chapter will deal with conclusion, limitations and possible further research.

2. CONTEXT: HISTORY, WELFARE STATE AND OBSERVATIONS ABOUT NORWAY AND FINLAND

In this chapter methods used and historical context are in focus. The welfare state is also introduced and what it means to Norway and Finland. It also includes how much GDP is used on the health care sector, how does one measure health and ideologies behind universal medical care. The historical context goes back as far as could be found, and because of my lack of reading Finnish the Norwegian context will go further back.

The historical similarities between the two countries are obvious, both countries have been under the control of Sweden, and got their independence in the 20th century. The original constitution of Norway is from 1814 (which is still in effect), and the original Finnish one is from 1919 (although the current one is from 2000). Other similarities are that neither had a common written language, but rather created one during the 19th century (Nynorsk in Norway and Finnish in Finland).

The historical context is not a major issue either since the systems that are in place have mostly developed in the same kind of “Swedish” influenced environment, with Sweden playing a big part on the organization of Finland because of its historical ties with the country from the 12th century to the 19th century, and in Norway as well because of the union with Sweden (1814-1905) following the Danish rule from 1397 to 1814. However, it should be pointed out that Finland was an autonomous part of the Russian Empire from 1809 to its independence in 1917. The time under Russian rule and cultural influence as well as throughout history could explain why Finland has a higher MAS index than Norway, Sweden and Denmark (Hofstede 1997; 2001).

The health care system is another story; the Norwegian system which was founded in 1603 which is much older than the Finnish one (or at least what I found) which came officially into effect in 1912. Although the early history (early 20th century) of these systems is similar, in task which were appointed to them, lack of funding and the structure of hospital system. However, this changed after the Second World War. (Järvelin 2002; Larsen 2003; Johnsen 2006.)

2.1. The historical context and the health system: Norway

Norway's National health care system was founded in 1603. However it was not until the early 1800's that any significant growth in the system occurred. This happened in at the same time with the Norwegian national building (after 1814). In 1811 the National University was founded in Oslo, and with the independence from Denmark and the following union with Sweden, both in 1814, the nation was to be built and national health should also be built. Norway's constitution was made in a short time between the independence from Denmark and Union with Sweden. During the Union with Sweden a national hospital was also built in Oslo in 1826. Around the middle of the 19th century the ratio of physicians to population broke the 5000:1 mark. The national health building was successful and at the end of the 19th Century Norway had a modern health service in and was truly a part of the modern Europe. (Larsen 2003; Johnsen 2006: 13.)

The act of 1912 implemented equal access to physicians regardless of patients income and where they lived; also at the same period of time municipalities hired physicians that were responsible for treating the sick who were poor. The time following the 1900, the focus of Norwegian health care was on tuberculosis, cholera and other infectious diseases, and was to keep the masses safe from the infected and thus the health care sector had a great effect on individual's life. People could be put in isolation, so the good of the many outweighed the good of the individual. There was an increase in public responsibility for both municipalities and state and several institutions were built for the sick and poor as well as for the general population. This was the main task of the health care system until the Second World War and the arrival of penicillin. In the years following the First World War the health care authorities focused on educating the population in how to stay healthy, and this continued until present day, but was especially prevalent in the 50's and 60's. (Larsen 2003; Johnsen 2006: 13–14.)

In the years following Second World War the welfare states growth became obvious. Politicians did not spend money on any project, unless the effect on the people's health was known (to a certain degree). Several hospitals were built, and institutions constructed. The governmental structure was changed for health care when the

directorate for health was established under the ministry of social affairs. There came a policy which gave physicians a new central role as professional practitioners, an increase in provisions for specialized services and a structure emerged of central, regional and specialized hospitals. (Larsen 2003; Johnsen 2006: 13–14.)

In 1967 the National insurance scheme (NIS) was introduced, which was passed to make a universal coverage for welfare services. Primary health care soared to new levels, and was as high as ever before. Politicians spent large amounts of money on health care, even with so much else to spend money on when rebuilding the country after the Second World War. The hospital act of 1969 implemented a unified system for all medical institutions. Following these act counties became responsible for planning, building and managing hospitals to meet the needs of the populous in all regions of the country. (Larsen 2003; Johnsen 2006: 14–15.)

In the 1970's the vast Norwegian hospital system had become so large and so costly that a rethinking of what people wanted and what people needed became a political issue. The political focus had then shifted with the need for more resources to other parts of the society (for example the large oil reserves found in the North Sea in the 70's). The Decentralized form of running the health care of Norway took place during the 70's, but changed radically in 2002 when the central authorities took control over the specialized health care services and divided the country into five regions. These five regions were responsible to give the best possible health care (within budget) to the population within the regions. The Municipal Health Services act of 1982 made the local authorities responsible for primary health care and all which fall under this. There is also trouble getting enough practitioners to cover sufficiently the more rural areas which is required under the Act of 1912. The consequences of this were that the directorate of health was abolished and the district medical officer disappeared. (Larsen 2003; Johnsen 2006: 14–15.)

In 2001 a scheme was introduced to give individuals the right to choose one GP (General Practitioner). The Norwegian system strives to be decentralized, but it since this is supposed to be an expression of applied democracy, and that delegation of power

leads to simplification when it comes to administration. However, with the money bag being held by the central government and the local government are to actively run the hospitals without controlling the money flow; this is more of a semi-centralized form of running the health care sector. The tension between local and central government is a sources of grief in the Norwegian health care sector. (Larsen 2003; Johnsen 2006: 15.)

The Norwegian hospital reform of 2002, lead from a decentralized system to a centralized system. In this system all specialist hospitals were now under the central governments control. This was a response to the increasing health care expenditures. When new standards for treatment were introduced also came with a money incentive and lead to a sharp increase in health care budgets. The ruling labor party “quit” this money incentive and instead centralized specialist hospital control. The Norwegian experience in centralizing hospital control has showed that for this to work shared responsibility must be the rule rather than the exception and that both local and central authorities need incentives to truthfully report the activity level at hospitals. (Hagen & Kaarbøe: 2006.)

2.2. The historical context and the health system: Finland

The Story of the Finnish National health service is different, in how the country looked at the time, and in what way they solved their problems. However, both Finland and Norway were not free countries during the founding of a national health service. They were in a blunt term vassal states. The Finnish Medical Association was founded on the 28th of February in 1910, and was an organization which tried to unite the medical communities, protect their interests and create a National health services. (Järvelin 2002: 14–15.)

This was successful as most of Finland's then 500 doctors joined immediately after its founding. In the beginning of the 20th century, there were few hospitals in Finland with most of them run down and in poor condition. As in Norway the biggest problems was tuberculosis and was the number one focus of the health authorities. In the years before

the winter war physicians realized that education of the population was important, and that they could not only go on treating illnesses. Instead they education of the population on health issues and a child welfare system was implemented in 1940's, this lead to better health for mother and child. Also in the 40's the municipalities formed federations, so-called tuberculosis districts, these where the prevention and treatment of tuberculosis was the focus. In the 1950's a shift towards building a central hospital system with the equality at the base commenced. About 20 central hospitals where built in the larger towns and most state owned hospitals where given to the smaller municipalities. The hospital and outpatient care should be administrated separately. (Järvelin 2002: 14–15.)

In the 1960's the health care system got criticism for being too little hospital oriented and requiring too much of financial and workforce resources. The argument was that prevention was the cheaper way to go, so campaigns against drug use, smoking and reckless driving where implemented. During this time district hospitals were built on municipal initiative. Following the decline of tuberculosis they redirected their resources to treat other diseases. The National Health Insurance (NHI) was introduced in the 60's. In the NHI patients got reimbursed for some part of the medical bill. (Järvelin 2002: 14–15; Finnish Medical Association 2008.)

During the 1970's the starting up of medical centers in all municipalities made health care more accessible for the rural population. However, the physicians lost a lot of the control of their work and became overworked and underpaid. In this period there were still substantial differences between patient care in urban and rural areas. The NHI did not remove these differences. An imbalance between primary and secondary health care was prevalent, with as much as 90% of expenditures on secondary, and a measly 10% on primary health care. So in 1972, Finland introduced the primary health Care act, this act obliged municipalities to provide primary public health care, as well as other services such as ambulances etc. The larger hospitals became multidisciplinary and focused on several aspects of health care such as rehabilitation, ambulance services, home nursing, preventative services and family planning. The NHI was further developed to also give compensation for income loss due to illness and refund a larger

part of private health care. In 1979 the occupational health act was introduced, and it gave employers the responsibility to supply occupational health care services to their employees. Rehabilitation also got a shot in the arm, when more resources were given. During the 1980's, social care and health care were put in the same five year planning and financial system and has since then been emphasized at all levels of government. In this period the health service grew and diversified, thus leading to a closing in the difference in supply and demand of primary and secondary services. There was also a development of a personal general practitioner (GP) system, but not through any act. This was an initiative of the local authorities to give better care over time. Later the GP system was developed towards a geographical approach, where doctors and nurses were responsible for a certain area's population. In the 80's, patient care and insurance against wrong treatment became a larger issue and in 1992, as the first country in the world passed an act which related to the patient's rights. (Järvelin 2002: 14–15; Finnish Medical Association 2008.)

In the 80's and 90's, legislations from the state shrunk to a lower level and a deregulation process followed. In 1991, two organizations were combined into one large organization, but did not work as planned and were soon after abolished. After the failure of the earlier organization, the tasks that previously had been done by the large organization was moved to a new ministry, which was created when the ministry of social affairs and ministry of health merged. The early 90's were characterized by the recession which took place worldwide at that time. There were several cuts in resources, and also lay-offs of health personnel which had not been predicted earlier. Following the mid-90s, the national economy of Finland has grown while the growth of financial resources used on health care were lower than the previous decade. (Järvelin 2002: 14–15; Finnish Medical Association 2008.)

In 1993, several major reforms in changed the finance of health care sector. The finance changed from a five year cycle of paying separately to primary and secondary health care to a system where money was allocated to the local authority, giving the municipalities' larger freedom in how to finance their health service. The money was now given on basis of the population and demographic of the region. By 2000, the

central government went into a dormant stage where they did not give any legislation, but rather monitored the system through research, evaluation, protocols, education, training and performance indicators. The Finnish system is a tale of success in the eyes of the population, with 80% of the population being satisfied with their system (which is the highest in the world), this according to a survey by the European Commission in 2000. (Järvelin 2002: 14–15; Finnish Medical Association 2008.)

2.3. Some «observations»: Finland versus Norway

Not long after the Second World War (1969) rich oil reserves was found offshore Norway, and soon after became the largest single industry that put money in the treasury of Norway. Finland did not have this income, but rather developed industries which later became a source of income (Nokia etc). (Järvelin 2002; Larsen 2003; Johnsen 2006.)

After the economical growth of the 80's a global recession hit, this led both countries to cuts in health care during early 90s. Because of Norway wealth there was less cuts in Norway's health care finance than in the Finland's. There was also an increase in Norway's bureaucracy to alleviate the rising unemployment. (Järvelin 2002; Larsen 2003; Johnsen 2006; Finnish Medical Association 2008.)

Before 2000 both countries had a de-centralized way of running their hospitals, but afterwards the Norwegian system has turned into a semi-centralized system which uses many legislations and ear marking of funds to control what is done on a micro level (hospitals etc), while in Finland there is a high degree of self control of the hospitals since most hospitals are owned and operated by the local municipalities. Often several municipalities go together to run a hospital. (Järvelin 2002; Larsen 2003; Johnsen 2006; Finnish Medical Association 2008.)

2.4. The welfare state

Both countries adopted a welfare state system, where there was little difference between poor and rich. This meant that in theory everyone should have equal opportunities and rights to health care. (Järvelin 2002; Larsen 2003; Johnsen 2006.)

Being both typical Nordic welfare model societies, and a welfare state can be defined several ways; in principle and in practice. In principle the Nordic states are in some ways exaggerated in its role, as NHS in the countries developed after the Second World War. A welfare state exists to protect the weaker of the society, and through different means, as taxes, social care (including medical insurance) and education. This is an attempt to create a more egalitarian society as well as to disband any walls which might create classes within a society. Thus leading to a more homogeneous society, where people are at least in the publics' eyes equal in that of the value of their lives. In other words the welfare state is there to redistribute the income the state has, where the quality of life for the people is most important (although it meaning most the people) and to give the same rights to all people within its borders. (Barr 2004: 7–9.)

Both Finland and Norway have around the same spending on the “welfare state”, where Norway spends (1998) 27% of GDP on it, Finland spends (1998) 26,5%, although the weighting of different benefits are distinctly different. Finland's Welfare state focuses more in the support for the working population, while Norwegian system focuses more on health care and other cash services (benefits to poor, etc). These differences in themselves are not especially large; they do show a different focus on what welfare state means to them. (Barr 2004: 9.)

The latest figures which are available through World Health Organization (2008) shows that the percentage paid in health care sector by private contributors is higher in Finland than in Norway, showing that the use of private clinics in Finland, paid through the NHI is higher than in Norway, who has much lower usage of private services in the health care sector. (Järvelin 2002; Johnsen 2006.)

Both Countries have what is referred to as Universal Medical Care (UMC), which is funded by tax money, and is publicly owned and/or controlled production factors. In UMC the goal is that everyone rich or poor should receive the same quality of benefits from the public health care sector. This type of coverage can be found in several other countries in Europe such as Sweden, France and the UK. (Barr 2004.)

The health spending in 2001 were (in US\$ PPP) 3012 for Norway (8.3% of GDP) and 1841 for Finland (7.0% of GDP) (Barr 2004: 275). Both countries have compared to the largest consumer of medical services, the United States of America very efficient health care. The USA spends more than 13% of their GDP on health care, while Norway and Finland spend 8,3% (Norway) and 7.0% (Finland). If the cost per head is used as measure the difference becomes even more evident with the US spending a massive 4887 US\$ per patient, while Norway spends about 3000\$, Finland on the other hand spends less than 1600\$ per patient, by far being the most efficient per patient. (Central Intelligence Agency 2008a; 2008b.)

3. THEORETICAL FRAMEWORK AND VIEWS ON MANAGERIAL VALUES, POWER AND RESOURCES

This chapter will deal with the theoretical and empirical aspect of the thesis and the theoretical framework described represent a choice among theories important when comparing managerial values across nations and cultures. The two single most important aspects are Hofstede's (2001) findings on the difference between Finland and Norway on the index of masculinity and femininity and McGregor's (1985) theory X and Y. However, the differences in legislation between the two countries are also of great importance even if they do not play a direct role on the values, but rather the manifestation of values. However this thesis does not focus on the structural differences (Järvelin 2002: 81–83; Johnsen 2006: 124–140).

The difference in legislation has given a degree of difference when coming to freedom of choice between Norway and Finland, as is concluded in *Health care in Transition: Finland and in health care in transition: Norway*. Both countries have inequalities in their system which needs to be dealt with. (Järvelin 2002: 85; Johnsen 2006: 155–158.)

The past 20 years in Europe has introduced an important change in hospital management, and in such changed from a global all covering global budget, to a hospital based activity-based funding scheme (ABF). The ABF is closely related to the American Prospective Payment System (PPS) which was introduced in the U.S. in 1983. (Hagen, Veenstra & Stavem 2006.)

This change in system showed an increase in efficiency, but there has been little research done on its association with the quality of care as seen from the perspective of the patient (client). A rare example of this focus on quality of care comes from the University of Oslo and its health economics research program (HERO). (Hagen, Veenstra & Stavem 2006.) This is not an aspect this thesis will work with, since the focus is mainly on the staff in these hospitals.

3.1. Hofstede

Hofstede's (2001: 41) research focused on as earlier mentioned the IBM corporation, where in 1967 and 1973 two rounds of surveys produced over 100 000 questionnaires from 72 countries. The indexes were found using factor analysis on the questionnaire which measured age, work goal importance and demographical indicators. In this thesis the most important of the five different indexes (see table 1 and appendix 6) is the MAS which was found by a country-level factor analysis on work goal importance and standardized for eliminating acquiescence. The findings showed that there was, not surprisingly, homogeneity within the Nordic countries Sweden, Norway, Finland and Denmark. However, Norway and Finland are replicas of each other in all respects but the MAS index (Hofstede 1997; 2001).

A country with high MAS index (higher number is more masculine) the individual person tends to focus more on ego specific goals like advancement, earnings and up-to-datedness of equipment. Countries with a low MAS index tend to prefer friendly atmosphere, position security and cooperation. This in short mean that a high MAS index country the most important aspect would be efficiency and the possibility to earn ego driven goals, while in countries with a low MAS index the focus would be on the social aspect within the workplace, rather than efficiency. (Hofstede 2001: 282.)

When referring to Hofstede's indexes this refers to the five indexes; power distance, uncertainty avoidance, individualism and collectivism, masculinity and femininity and Long versus short- term orientation. These five indexes are the basis of Hofstede's (2001) cultural assessment. Four of the above index short of the last are from the original IBM surveys (Hofstede 2001: 76–82, 315–350), however the long versus short-term orientation is computed from consumer survey (EMS97) and marginal propensity to save in percentages (Hofstede 2001: 357). See Appendix 6 for more information on Hofstede's indexes.

Table 1. Hofstede's (1997; 2001) indexes for Norway and Finland.

	Finland's Index	Norway's Index
Power Distance	33	31
Uncertainty Avoidance	59	50
Individualism/Collectivism	63	69
Masculinity/Femininity (MAS)	26	8
Long Vs Short term orientation	41	44

- Sweden's MAS index is 5

Arrindell and Veenhoven (2002) found that the correlation between feminine values in rich countries and happy life expectancy (HLE) were strong. In this study Norway got an HLE of 57.08 while Finland got one of 56.19. The numbers show that the number of HLE is similar in both countries, and would not be sufficient to be taken within this thesis. Arrindell and Veenhoven (2002) admit that further study with a larger sample is needed for this to be proven either way.

Bryne and Bradley (2007) found that the cultural values of managers is stronger than the personal values on the mediation effect of manager leadership style, This means that almost 70% of managers leadership style is based on cultural values. However, Bryne and Bradley's studies sample is limited and has not been verified as of yet.

To further illustrate Bryne and Bradley's (2007) point, an article by Pizam, Pine, Mok, and Shin (1997) focused on hotel industry in Asia (Hong Kong, Japan and Korea). This shows that the five indexes of national culture indicate strongly in which way these hotels are managed, showing that national culture is a more potent influence rather than the industrial culture (sector culture or organizational culture). Hofstede's (1997) and others assumption about national values (culture) is more influential than personal attitudes. This in turn affects individual behavior (managerial behavior). This means that the managerial behavior of Norwegian managers and Finnish managers would be different even if the cultures exist close to one another because of the difference in MAS index (Hofstede 1997; Piza et al. 1997; Bryne & Bradley 2007). For example Japan has

had a great influence on Korea in its history with continuous invasions through the centuries (Pizam et al. 1997).

The hospitals in this thesis are similar in most respects. However, the Hospital in Vaasa is founded in a bi-lingual city (Swedish and Finnish) and is therefore not a typical Finnish city. 25% of the population in the area surrounding the hospital is Swedish speakers and therefore it is safe to assume that it is more influenced by Swedish values than the parts of Finland which are not bi-lingual. It is important to note that Sweden has a lower MAS index than Norway, and that this will inevitably influence the MAS index found in the leaders and workers at the Hospital in Vaasa.

The health care sector is a typical female profession, even if a large number of the doctors are men, or traditionally have been men. It is not like this today, an increasing number of the physicians are now women, while the same cannot be said for nurses. Nursing is still considered a “women’s” profession; still the number of men within this profession is rising although most nurses are still women.

3.2. McGregor theory X and theory Y

Managerial theory is heavily influenced by McGregor's (1960) book *the human side of enterprise*. In this book and the theory X and Y within this book were heavily influenced by the psychological and psychological theory of Abraham Maslow needs hierarchy and especially the final step of self actualization. (McGregor 1985; Maslow 2004: 123–130.)

In theory Y, which is the one based on self actualization, there should be a belief in human growth and self-actualization through an environment within an organization which is based on trust, feedback and containing real human relationships. Furthermore this requires active participation by everyone involved. The managers should concern themselves with their workers individual dignity, worth and growth. There should be little or no coercion, but rather an atmosphere of openness where people can work out

their differences together. There should also be a strong relationship, a proper human relationship between superiors and subordinates. (McGregor 1985: iv–viii.)

Theory X is characterized by thinking in which men avoid work, and prefer to do nothing, according to McGregor (1985: 33–34) theory X can be summarized in three points:

- “1. The average human being has an inherent dislike of work and will avoid it if he can.
2. Because of this human characteristic of dislike of work, most people must be coerced, controlled, directed and threatened with punishment to get them to put forth adequate effort toward the achievement of organizational objectives.
3. The average human being prefers to be directed, wishes to avoid responsibility, has relatively little ambition, wants security above all.”

While Theory X is quite pessimistic concerning human nature and behavior, theory Y could be called overly optimistic concerning human nature. Theory Y is summarized in six points according to McGregor (1985: 47–48) himself:

- “1. The expenditure of physical and mental efforts in work is as natural as play or rest.
2. External control and the threat of punishment are not the only means for bringing about effort toward organizational objectives. Man will exercise self-direction and self-control in the service of objectives to which he is committed.
3. Commitment to objectives is a function of the reward associated with their achievement.
4. The average human being learns, under proper conditions, not only to accept but to seek responsibility.
5. The capacity to exercise a relatively high degree of imagination, ingenuity, and creativity in the solution of organizational problems is widely, not narrowly, distributed in the population.
6. Under conditions of modern industrial life, the intellectual and potentialities of the average human being are only partially utilized.”

While it is true that this was put forth by McGregor in 1960 does not necessarily mean that it is no longer valid. The theory is still used and refined as shown by Kopelman, Prottas and Davis (2008). These theories are also not possible to have in a “pure” form. Theory X is one extreme, hence theory Y the opposite and other extreme. While there are now only four questions on the questionnaire for this thesis that measure to which degree its either theory X or Y it has been over 30 questions at the highest (Kopelman et al. 2008: 260).

McGregor's famous theory X and theory Y will be used as a measurement of how employees relate and agree with statements that were put forward originally by

McGregor (1985) himself, but later revised to a set of 4 questions (Kopelman et al. 2008). The answers will be set on a horizontal axis, where there are 6 points of agreement, from strongly disagree to strongly agree (Likert Scale).

The values which the survey found are put into a value system (see figure 2), in which some values dominate others. The outcome of this hierarchy of values will be a value system. This is the moral compass which is used to make sense of the world and guide an individual through life (French & Raven 1959; Geertz 2000: 141; George & Gareth 2006: 694). The differences in the system may provide a glimpse into the reason why the Norwegian health care system is less efficient than the Finnish one (Kittelsen, Magnussen & Anthun 2007: 10). This will be done through McGregor's (1960; 1985) theory X and Y.

There are only a certain number of values which this thesis is based on, these being mainly the theory X and Y as a function of Hofstede's (1997; 2001) masculinity and femininity index, but also job satisfaction, trust in managers and wellbeing of employees in their work place.

3.3. Hospital management values

To define this: this is the underlying values which a manager has dialog with while making decisions for the hospital. This means that leadership is affected through the Manager's own values and training. These values and the larger value system (figure 2. and 3.) will be measured within McGregor's theory X and Y (as hard and soft values), as well as a much simpler time versus money scale.

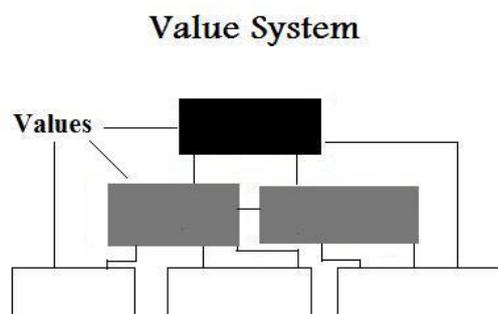


Figure 2. Value system and values.

The goal of the questionnaires and interviews is to find which grade the employees' feelings on a scale for several aspects, and thus exploring to which extent on the theory X and Y scale the hospitals managers make the employees work. This could be either hard or soft value, or that they value efficiency in the focus of less money, more time or vice versa.

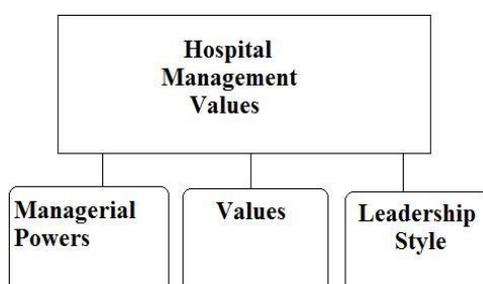


Figure 3. Hospital management values.

3.4. Resources

From the time of independence (1905) the growth especially from around 1970 has lead Norway to be among the richest countries in Europe (per Capita) and with a large welfare based government and bureaucracy. The country has a large money reserve

invested in foreign businesses and has a large national surplus. The recession in the late 80s and early 90s lead to a growth in bureaucracy in order to lower unemployment caused by this recession. In comparison the Finnish bureaucracy in the same period underwent changes, to make it more streamlined and efficient. A large bureaucracy with several steps means that the efficiency is lower, both in time spent on each case and in money consumed by the bureaucratic machine. Which means the following statement might be correct “the bureaucracy is expanding to meet the needs of the expanding bureaucracy”.

3.4.1. Time and money: time is money? quality of decision making

Time is not Money, a quick decision might be better than a slow decision, but if the quick decision is a poor one and costs a lot of money, then one could rather say money is time, not the other way around. There is however very little to show that a difference of time for making a decision (15seconds to 120seconds) makes a decision better, the difference mostly visible when comparing high time pressure (imminent 15s-120s) and no time pressure at all. (Kocher & Sutter 2006.)

On the other side in an article called time is not money by Tore Ellingsen and Magnus Johannesson (2006) shows that Swedish business students do not treat time as money, but rather much more liberal with their time, but being greedier with their money. This means that time is not valued highly such as the statement “time is money” would suggest.

3.4.2. Macro: national finances Norway and Finland

According to World Health Organization (2008) last health care in transition (Finland 2002 and Norway 2006), Norway’s National Health care System (NHS) is semi centralized Compared to Finland a higher degree of bureaucracy, meaning the hierarchical structure from government to municipal government and hospital is longer and containing more steps for the money and requests from central government to hospital. (Järvelin 2002: Johnsen 2006).

Table 2. Norwegian health care in numbers.

Finance of Health care by Private/Public in 2006	85% Public 15% Private
Health care spending in % of GDP in 2006	9,60%
Expenditure per patient in 2008	2370 Euro
Total GDP(Purchasing Power Parity (PPP)) in 2007	247,4 Billion USD
Health care budgets in Euro (PPP) in 2007	23,8 Billion USD
Admissions in 2008	0,82 million cases
Total expenditure on health care in 2005	18% of budget
Average stay in hospital in 2004	7,5 days
Population in 2008	4,6 million inhabitants

*The numbers in the table are from Central Intelligence Agency (2008a), World Health Organization (2008) and from Johnsen (2006)

Table 3. Finnish health care in numbers.

Finance of Health care by Private/Public in 2002	76% Public 24% Private
Health care spending in % of GDP in 2002	7,30%
Expenditure per patient in 2008	1350 Euro
Total GDP(Purchasing Power Parity (PPP)) in 2007	185,5 Billion USD
Health care budgets in Euro (PPP) in 2007	13,4 Billion USD
Admissions in 2008	1,36 Million Cases
Total expenditure on health care in 2005	11,6% of Budget
Average stay in hospital in 2004	10 days
Population in 2008	5,2 Million inhabitants

*The numbers in the table are from Central Intelligence Agency (2008b), World Health Organization (2008) and from Järvelin (2002)

3.4.3. Macro: Norway Vs Finland

Main figures are presented in tables 2 and 3. The decentralized NHS of Finland contains less bureaucracy than the Norwegian system. Therefore also this might affect the efficiency of hospitals in these two countries. The finance of the health care sector is in Norway funded 85% publicly and 15% private, compared to Finland health care funding which is 76% public and 24% private. The overall GDP percentage spent on the health care sector is 9,6% of the Norwegian GDP, while it 7,3% of Finland's GDP (2002), the expenditure per patient is 2370 Euro (Norway) and 1350 Euro (Finland). The total GDP (Purchasing Power Parity = PPP) is 247,4 billion US\$ In Norway and 185.5 billion US\$ in Finland. Meaning that the health care budgets in 2002 were 13,4 billion US\$ in Finland and 23,8 billion US\$ in Norway. The number of hospital admissions is lower in Norway than in Finland, and by over 500 000 per year in 2002 (Finland: 1,36million; Norway: 0,82million (World Health Organization 2008)). This even with the population in these countries being almost identical with Norway having 4,6 million and Finland 5,2 million inhabitants (Central Intelligence agency 2008a; 2008b).

The total expenditure in terms of income by the Norwegian and Finnish governments on public health care was in 2005 18% in Norway and 11.6% in Finland (Not to be confused with percentage of GDP). Norway spends more than the average of western European countries on health care, while Finland is just below the average when compared in percentage of total governmental expenses (World Health Organization : Europe 2008). The average stay of a person in hospital in each country has a difference of 2,5 days, with Norwegian patients staying an average of 7,5 days in hospital and Finnish patients 10 days in 2004. This shows that the expenditures for one day in a Norwegian hospital bed are higher than a day in a Finish bed. (Järvelin 2002: Johnsen 2006.)

The numbers here presented can show how the Finnish health care system while spending less money, accomplishes more that what the Norwegian system does. This is a subjective meaning, since the numbers do not actually say that, it merely implies that it is so. Organization for Economic Co-operation and Development (OECD) has shown

that Finnish doctors are up to 80% more efficient than their Norwegian counterpart. However, this is according to the president of the Norwegian doctors association Torunn Janbu not the case, and reports that OECD is incorrect because of problems gathering data from Finnish doctors, leading them to have fewer doctors per 1000 population than there actually is, artificially increasing the efficiency of the Finnish doctors in the OECD report. (Dalsegg 2008a; 2008b.)

This is said to be because of different procedures of reporting cases, and difference in measuring success (Dalsegg 2008a; 2008b). This statement leads me to check further into the subject, but on paper the hospital of Vaasa is between 30% and 35% more efficient than Ålesund hospital. At national levels, when nonparametric data envelopment analysis was used the difference in efficiency was between 17% and 25% in Norwegian Hospitals (Linna, Häkkinen & Magnussen 2006: 1). A non parametric data envelopment analysis is in short a way to measure the efficiency of a private or public sector unit (Subhash 2004).

3.4.4. Micro: comparison of Ålesund and Vaasa hospitals

The economical data is gathered from the two hospitals financial statements available at Helse-Sunnmøre (2008) and at Vaasan Keskussairaala (2008) with main data presented in table 4. These two hospitals even if responsible for cities of the same size have vastly different budgets. Whereas the numbers found at the hospital website for Ålesund hospital budget is over 100 million Euro (16 million higher after GDP equalizing) higher than Vaasa hospital while at the same time Ålesund hospital is treating around 100 000 fewer patients in 2007. Even when accounting for the difference in GDP per capita in the countries (51% higher in Norway than Finland (Central Intelligence Agency World Fact Book 2008a; 2008b). Operation costs in Norway are much higher per patient rather than Finland. (Central Intelligence Agency World Fact Book 2008a; 2008b; Helse-sunnmøre 2008; Vaasan Keskussairaala 2008.)

Table 4. Operation costs: Ålesund and Vaasa hospital (Helse-sunnmøre 2008; Vaasan Keskussairaala 2008).

Numbers from 2007:	Ålesund	Vaasa
Operation cost Hospital	244 375 000 Euro	151 258 943 Euro (+51%) 228 401 004 Euro
GDP per capita	36852 Euro (53000US\$) +51%	24545 Euro (35300US\$) ---
Total Treated per year Hospitals	179525 Cases	276722 Cases
Cost per Patient (case)	1361 Euro	670 Euro (+51%) 1011 Euro

The number of beds available at hospitals has steadily declined from the mid 80s till today in both Norway and Finland. On the other hand the number of doctors has increased in the same time period in both cases. In Norway the number of nurses was cut in 2000, and is now again rising. The number of Nurses in Finland has on the other hand steadily increased since the mid 90's. (Järvelin 2002; Johnsen 2006.)

These hospitals are chosen not only because of the fact that they are close to where I live and spend my time, but that they serve a city roughly the same size (50,000 inhabitants). I theorize that because of different recourses and different systems in which to measure efficiency the numbers are actually closer than they seem, and that discrepancy can be attributed to different management styles, and the values inherent in these. Vaasa is as mentioned not a typical Finnish city, since there is a large minority of Swedish speaking Finns there. What can be determined by the numbers is that both these hospitals are efficient beyond the national average by using close to 50% of what the national average is when treating patients. So in that retrospect neither of these hospitals are average according to their efficiency when treating patients. (Järvelin 2002; Johnsen 2006; Helse-sunnmøre 2008; Vaasan Keskussairaala 2008.)

3.5. Managerial powers and values

The basic managerial powers as shown in figure 4. are as follows, expert, referent, reward, legitimate and coercive. The questionnaires used in this thesis map to which extent the subordinates feel their manager is using one or the other of these powers. Another aspect is the manager's consideration of the employees.

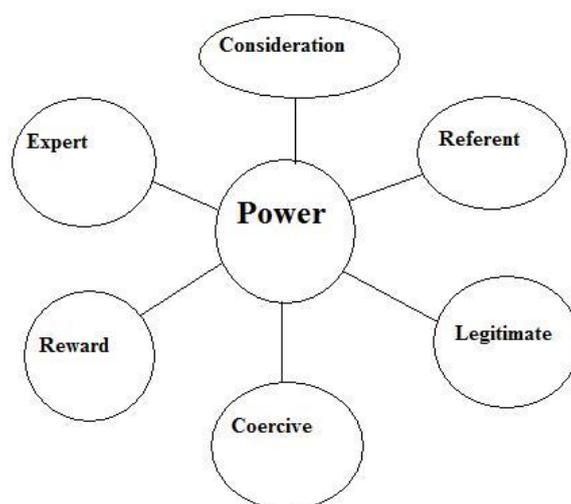


Figure 4. Managerial powers

The powers which a manager has available are these (George & Gareth 2006: 305):

- **Expert:** This is based on the special knowledge and skills which the leader incorporates. This is a given power, something which is acquired; this is a “hard” value based power. But unless it is used to threaten a subordinate I will refer to this as a neutral power, which can be used in both a hard and soft way. (Gaski 1986; George & Gareth 2006.)
- **Referent:** Is an informal kind of power which comes from the personal characteristics of the leader, where the co-workers and subordinates like them, the respect them and stay loyal towards them. This is a typical “soft” value power

where human interaction is the main factor, and interpersonal relations are subjective. (Brown, Lusch & Nicholson 1995; George & Gareth 2006.)

- **Legitimate:** This is the power which a leader has by virtue of his position; leadership style is important factor in determining which way this power is used. This is a typical “hard” value power, where the hierarchy decides what effect this power has, however it will depend on the structure of the organization (Flat Vs Hierarchical organization). (Brown, Lusch & Nicholson 1995; George & Gareth 2006.)
- **Coercive:** This is the power of punishing the subordinates; there are many different ways of doing this, ranging from verbal lashing to reduce pay or firing the individual. “Hard” value power, which is using a stereotypically masculine approach to exercise the power. (Brown, Lusch & Nicholson 1995; George & Gareth 2006.)
- **Reward:** The power of praise, pay raise, giving bonuses. Both tangible and intangible rewards can be given or withheld to mobilize this power. This is more difficult to categorize according to Macgregor's Theory “X” and “Y”, but is more a “soft” value power, since reward is more about using the carrot, instead of the whip to move the horse. (Comer 1984; George & Gareth 2006.)
- **Consideration:** Not a power, but a trait used by managers, this is a soft value tool which a manager possesses and which can be used to increase efficiency by reducing turnover, increasing confidence at work (for employees) and raise wellbeing at work in general. (Lucas, Parasuraman, Davis & Enis. 1987; George & Gareth 2006.)

There are 16 questions about the five basic managerial powers on the questionnaire, and two questions on consideration. These powers and consideration are therefore together with McGregor's theory X and Y and job satisfaction are the basis for the questionnaire.

3.6. Hard Vs soft values

The “hard” values, often also called masculine values are those that are easier to

measure, for example efficiency, in its narrow form, input of a 1000€ gives “products” of a 1000€ as 100% efficiency. While the softer values are more subjective, what does the customer think of the product delivered, and what could be improved.

Customer satisfaction is a way of trying to quantify these subjective numbers given in surveys. This is a much more feminine or “soft” way of focusing on efficiency and in accordance with Hofstede (1997) Finland has a higher degree of “hard” values in the public health care system while the Norwegian system tend to lean against “softer” values (26 Vs 8 in MAS). Soft and hard values will be used in this thesis as the main definition of differences of values. (Nymark 2000: 19.)

Each level of figure 2 contains values, but the one that is the top of the hierarchy is the one which influences all other variables. This is the level of national values, which are contained within the national culture. The powers which a manager has available is also influenced by national culture, and values, what is the “good” way of doing things, what makes a decision a “good” decision? What is the overall goal of the decision and is the process, and consequences of the decision seen in a narrow or broad point of view? (Geertz 2000; Hofstede 1997.)

These are all questions which are important in the process of decision making, what is defined as good in the national or for that matter the organizational culture? To clarify this idea let us take an example. If the leader of an organization wants to increase efficiency in the narrow point of view, and you have three options available to reach this, what is the main focus of the decision? What values are dominant? (Geertz 2000; Hofstede 1997.)

The countries have according to Hofstede (1997: 84) different Masculinity indexes (MAS), for Finland it is 26, while for Norway it was 8, however this number is not to be an absolute. Such as Håvold (2007) in “from Safety Culture to Safety Orientation” found a much higher number using Hofstede’s scale, it should however be noted that the people used as basis for surveying in these two studies are quite different. Hofstede's (1997) findings were based on office workers in Oslo, while Håvold's (2007) study was

done on Sailors from the west and northern part of the country. Fishermen in Norway are seen as Masculine, and typically a “hard” profession.

4. METHODOLOGY

Both quantitative methods and qualitative methods have strengths and weaknesses. Quantitative methods can provide a high level of measurement precision while qualitative methods can supply greater depths of information about attitudes, perceptions, relationships and performance in a particular research setting.

The methodology in this thesis is divided, where as you have the survey on the quantitative aspect, and the interviews for qualitative aspect. The base will be the answers given on the questionnaires, using the statistical findings procured from the answers given. The interviews are contextual, without the interviews the findings in the questionnaires will be without any context, or cross reference.

4.1. Questionnaires

The questionnaire was designed to cover key factors found in a result of a review of literature mainly based on answering the main research question: «What are the underlying causes of a difference in efficiency between hospitals» and figure 1 Framework of analysis showing a model with the factors used to determine Hospital Management Values, the questionnaire is attached in Appendix 2.

The questionnaires are built upon the managerial power aspect (see chapter 2.3), McGregor's **theory X and Y** and **time versus money**. The powers are **reward, coercive, expert, referent** and **legitimate** (Comer 1984; Gaski 1986; Brown, Lusch & Nicholson 1995). In addition to the five powers in the managerial power aspect, there are questions which are to show to which extent the leadership style of the manager / supervisor is **considerate**, as perceived by the subordinate. A considerate style implies that there is a good working relationship between the superior and the subordinates, and is commonly characterized by respect, trust and friendliness (Lucas et al. 1987). A second addition is questions relating to **work satisfaction**, to measure to which extent a person is satisfied with his or her job (Rich 1997). The third addition is to which extent

the subordinates feel that they can trust their superiors / manager's reliability and integrity (Rich 1997). Finally additional questions regarding the **wellbeing of employees** are added. These 12 questions are from to Buckingham and Coffman's book *First, Break All the Rules* (1999) and if they are answered on average below 4 (out of 6) the manager should be concerned since this would lead to a higher turnover, higher absenteeism and lower efficiency.

Table 5 shows the factors/scales used in the questionnaire, the source of the factor and the reliability measure (Cronbachs alpha) showing inner consistency in the measure. The questionnaire in appendix 2 shows the items used in each factor.

Table 5. Factors used in questionnaire

Factor/Scale	Question/Items	Source	Reported reliability Cronbachs alpha
Money	9 to 11	Self developed	
Time	12 to 14	Self developed	
Power Coercive	15 to 17	Brown et al. 1995	.84
Power Expert	18 to 20	Gaski, 1986	.77
Power Legitimate	21 to 23	Brown et al. 1995	.73
Power Reference	24 to 26	Brown et al. 1995	.68
Power Reward	27 to 30	Comer 1984	.88
McGregor	31 to 34	Kopelman et al. 2008	Not reported
Leadership style	35 and 36	Lucas et al. 1987	.77
Work Satisfaction	37 to 39	Rich 1997	.82
Trust in manager	40 to 44	Rich 1997	.94
«Climate»	45 to 56	Buckingham et al. 1999	Not reported

Even though some of the factors/scales originally used a 5 point Likerts scale, this research chose to use a six point scale (seven point scale without neutral position).

4.2. Interviews

A qualitative interview is a research tool /method and themes and questions were prepared in advance, this in an attempt to get people to describe their experiences on their own terms. The qualitative researcher philosophy determines what is important, what are ethical, and the completeness and accuracy of the results (Rubin & Rubin 1995: 2).

A total of 8 interviews is conducted, 4 at each hospital. Seven of the interviews were conducted face to face, one by telephone. These are done with leaders, both in department leaders, as well as ward leaders. The interviews ask if not the same questions, quite similar ones. However in the interviews the subjects are encouraged to explain what they see as the problem and how they feel that this can be solved (see appendix 1 and 2).

The questions are about experience and training of the managers, how long they have had their current position, resource situation in their department, how they feel that they communicate within their department, and in which way they do so, to which extent they trust their employees and how much time is being used on thesis work or similar tasks (see appendix 1).

The interviews are afterwards transcribed and analyzed for the purpose of comparing countries, but not departments (see chapter 5.2 and subchapters). There are 11 questions, not including follow-up questions which differ depending on the answers given. The questions are not exactly the same in all interviews depending on both language skill of the informant, and depending on if earlier questions answer other questions which are prepared.

4.3. Reliability and validity

Reliability refers to how consistent a measuring device is. A measurement is said to be reliable or consistent if the measurement can produce similar results if used again in

similar circumstances. Reliability mostly concerns quantitative studies but the quantitative researcher is also questioned whether the measure is stable or not. (Bryman and Bell 2007: 40.)

In order to attain reliability in the thesis and to be consistent in the questions, the questionnaire is based on theories. For internal reliability which is about whether the indicators that make up a scale are consistent or not, we can say that our indicators are coherent and has been tested for inner consistency by using Cronbach Alpha. A possible threat to case stability, which is the consideration whether the measure is stable over time, can be present since the perception of people changes over time.

Validity refers to whether a study /questionnaire measures or examines what it claims to measure or examine. For example do the items in the survey measure the values or powers it intended to measure or does it measure some other construct. There are different aspects of validity such as measurement validity, internal validity and external validity. Normally do interviews claims to have a high internal validity (i.e. credibility, believability, plausibility of findings and results) while surveys claims to have high external validity (i.e. applicability of the study's findings, results and conclusions to other circumstances). The survey is analyzing the perception of the hospital employees by asking simple and easy questions that are understandable and used in previous research. To obtain high validity most of the items in the questionnaire were based on theories McGregor theory X and Y (Kopelman et al 2008); managerial powers (George & Gareth, 2006); work satisfaction and trust (Rich 1997) and climate (Buckingham & Coffman 1999) and organized as simple as possible in the questionnaire. Therefore it can be argue that the thesis' measurement validity is fairly high.

The triangulation approach with both qualitative interviews and quantitative survey can be viewed as a mutual confirmation of measures and validation of findings.

5. A COMPARISON AND DISCUSSION ABOUT MANAGEMENT VALUES AND RESOURCES AT ÅLESUND AND VAASA HOSPITALS

This fifth chapter outlines the statistical and empirical findings of the research. The chapter deals with both the quantitative findings and the qualitative findings and put these two parts together in the discussion.

5.1. Questionnaires and interviews: statistical data

The data was registered on SPSS: PASW statistics 17 (Statistical Package for Social Sciences). A t-test (also known as a student's t-test) was used to test if the difference in factors (see table 5) between Norway and Finland were statistically significant. The factors are money, time, coercive power, expert power, legitimate power, referent power, reward power, McGregor's theory X and Y, leadership style consideration, work climate (autonomy, motivation and work adaptation).

A total of 137 questionnaires were collected during the first three months of 2009. The questionnaires were handed out in the respective hospitals. The response rate is calculated to around 50%. The sample consist of 88 persons from Norway, 45 from Finland and seven from other countries; 17% of the sample were male; 15% of the sample were doctors, 70% nurses, 7% junior nurses and the rest were in the other employment category. 21.9% of the sample had some kind of "management" position.

The factors used in the analysis are constructed in accordance with the information given in table 5 and the questionnaire in Appendix 2. The questions/items relating to each factor is summated and divided on the number of questions/items to reach an average. Instead of using 46 questions in the analysis one ended up with a simpler "model" analyzing "only" 14 factors (see appendix 3) using summated scales. The reliability of the factors/scales was tested by using Chronbach Alpha (testing inner consistency of the measure, so one can confirm if the items/questions measures the

same construct). All Cronbach Alphas on the factors/scales were above .6 which is satisfactory (Hair, Anderson, Tatham & Black 1995). From Appendix 3 as we can see the difference between the two countries is negligible on many of the factors. The reported standard deviation tells us about the variability or dispersion of the population, within one standard deviation from the mean one finds 68% of the answers/observations given (lower number means less spread from the mean) and 95% of answers lies within three times the standard deviation. A low standard deviation indicates that the data tend to be very close to the mean.

In the next sub chapters the quantitative factors and the qualitative interviews will be discussed. Traditionally, experimenters have used the 0.05 level (sometimes called the 5% level), although the choice of levels is largely subjective. The lower the significance level, the more the data must diverge from the null hypothesis to be significant in other words the lower the number, the more significant it is.

5.1.1. Money

Table 6 shows a highly significant difference in scores on money between Norway and Finland (significance = .000). The money factor which I use to measure to which extent money is an issue at the work place, the importance of money (three questions) shows a significantly higher mean in Norway as that it is in Finland. There are several reasons why this is implied by the findings. One of the reasons to this can be found within the Interviews where several of the Norwegian managers and middle managers complained about a lack of funding. When answering the following question: Can you explain the resource situation? The similarities in the Norwegian interview answers are obvious. However the diversity of the Finnish interviews must be addressed.

Table 6. Money

Factor	Nationality	Respondents	Mean	Std. Deviation	Significance
Money	Norway	88	4.7765	.70343	.000
	Finland	41	3.9593	.92854	

“Well the resource situation can in periods be a challenge...[Sig] the development of current employees, more resources for that, this since the resources that were originally meant for this, is now used in the running of the department to sustain the regular running” (Norwegian informant).

There are also several others of the Norwegian managers that felt like this.

“When I started in 1990 there were «good times» and whatever deficit we had, we were «forgiven» the next year, and now we have a budget, and that’s the budget we have... nothing more, so we have to keep it within the budget. So if we use much money in one place, we need to cut back in another place, it was not like this 5-6 years ago, back then everything u did u got «forgiveness», so if we get a lower budget in 2009 than we have in 2008, it will mean that 5 positions will have to be canceled..... We get more and more people, but also more and more assignments to complete, tasks that are our responsibility. If we should complete all assignments and all tasks, we could have infinite people. So I have given certain things priority. What are we to do in the health sector and what are we to do at thedepartment, so I wish that I had more people... Yes...” (Norwegian informant).

“In busy periods, with lots of patients, or with what we call”heavy” patients... Patients that require a lot of attention. Then the staff is less willing to take extra shifts because they get tired and worn out more quickly, and we also see a small rise in sick leave of the staff. So when we require more resources, we see that the resource situation falls because of too much pressure on the staff, while in periods of lower intensity it is more the opposite. The staff wants to work more, so they almost argue of who can take the extra shifts” (Norwegian informant).

“There is no resource problem in Norwegian health care, but rather a distribution problem, and this is because the logical restructuring that should be done in accordance with Qualitative reasoning cannot be done, since the sector is controlled by politics” (Norwegian informant).

There is according to all the managers that have been interviewed a lack of resources, mainly money that is either missing or focused on the wrong part of the hospital or not available at the right time.

“In certain periods when the pressure gets very high, or when we have resource demanding patient, we cannot give good enough services. It can be like that in some periods, but mostly we provide the services we are suppose to... [Sig] So in certain periods we have to little resources, but mostly this works fine” (Norwegian informant).

While in Finland money was less of an issue, and that they lacked the personnel rather than the funding for the running of the hospital. However the lack of personnel could be from lack of money.

“Money is limited... but one could educate and improve as long as there is an interest for this, so that money is not the only thing that affects the development. But it’s probable that it will get even harder to get nurses....a lot of people retire, and education of new people is low. There will be more nurses retiring than new nurses educated. We have two schools here, the Swedish and the Finnish one, so it’s probably easier here than in other parts of the country” (Finnish informant).

“There has always been some lack in specialized doctors, so I have had to fill in often. And now I have the least doctors I have ever had. It has always been cut backs since I got a management position, every year. A lot of prioritizing is needed” (Finnish informant).

Personnel seem to be the main resource lacking within certain segments of the hospital of Vaasa. However according to other informants, this is not a problem in all departments.

“At the moment I think that the resource situation is good in our area, because we have enough people and money. However, the last few years the economical situation has been worsening” (Finnish informant).

“People are the most important resource in the hospital, we need money, but we can do a lot without a lot of money. I think we have enough money right now, I have enough now. I don't need more people. I have sufficient at the moment” (Finnish informant).

The standard deviation also implies that there is a larger difference between Fins opinions than Norwegians opinions. This can explain the larger diversity of the answers in the interviews compared to Norwegian interviews on this question. The difference in number of replies is also a possible explanation for difference in the importance of money.

5.1.2. Time

Table 7 shows a highly significant difference in score between Norway and Finland (significance = .000). Time as a factor, the importance of time in the work place is more similar than money, when the mean is compared between the countries. There is a difference of 0.66 of the mean answer, compared to the 0.82 mean difference of money. The standard deviation of the answers from Norway is higher than in Finland, this implies that there is a larger difference in the answers given by Norwegians. The standard deviation in Norway when answering questions about time is almost to the same level of which the standard deviation is in Norway when answering questions about the money factor.

Table 7. Time

Factor	Nationality	Respondents	Mean	Std. Deviation	Significance
Time	Norway	86	4.8295	.83821	.000
	Finland	41	4.1707	.65031	

The implications of this result is that time is less important factor in Finland than in Norway, but that the difference in opinion in Norway is greater than in Finland. One of the informants in Norway gives a description of how he feels that the lack of money, leads to a lack of administrative personnel which further leads to a lack of time.

“Well that is in connection with the problem that there is so much paper that needs to be done, we are not “paperless” as of yet. I have no secretary, or anyone with that function. It is also a problem that doctors which are department heads also have clinical work in addition to administrative duties. They also have less support functions (secretaries etc) than ever before.” So you feel that your overloading with so many functions based on yourself? That is right, so that I also become the coordinating link towards the (hospital) administration here. I wish we had more freedom and more personnel available here at the department. The personnel control is two sided, with one dealing with the department needs, and the rest with the whole of the administration needs. We should have had every function at the department level so that we could plan for month to month and then changed it into an analytical function and then we should have meetings” (Norwegian informant).

The link between money and time is implied in that the lack of one leads to the lack of the other. Money seems to be the overall factor which controls time factor as well, with the lack of money there is also a lack of time.

5.1.3. Coercive and reward power

Both coercive and reward power show significant difference in the scores between Norway and Finland (Table 8: Significance coercive = .038 and reward =.002). The coercive power can be described as the power of punishing the subordinates; there are many different ways of doing this, ranging from verbal lashing to reduce pay or firing the individual, this power had been inverted, so that a higher number indicates less use of such power (Brown, Lusch & Nicholson 1995; George & Gareth 2006.)

Table 8. Coercive and reward power

Factor	Nationality	Respondents	Mean	Std. Deviation	Significance
Power coercive	Norway	87	5.5594	.50449	.038
	Finland	41	5.3252	.73970	
Power reward	Norway	82	4.0183	.79716	.002
	Finland	38	4.4539	.43049	

This power can be described as a hard value power. The opposite is the reward power, which is described as the power of praise, pay raise, giving bonuses. Both tangible and intangible rewards can be given or withheld to mobilize this power. (Comer 1984; George & Gareth 2006.)

The results indicate that the hard value coercive is weaker in Norway than in Finland, but this by a quite small difference. However, there is a larger spread of answers in Finland than in Norway, which implies that there are larger differences between leaders leadership style than in Norway. The results indicate that there is a higher level of use of the soft value reward in Finland with a difference of 0.44. The standard deviation indicates that there is a higher usage of reward power in Finland, there is not much difference, but there is a difference, and the standard deviation in Norway implies that there is a less usage of this power, either by not believing in the use of this power, or the lack of possibility to use this power because of the system structure. This might also be true in Finland's case. Both findings are statistical significant, but the finding of reward power is 99.8% significant. This meaning that the hard value is less used in Ålesund hospital, but also the soft value reward. This might indicate that the structure prohibits the use of certain powers.

5.1.4. Legitimate and referent power

Table 9 shows that neither legitimate power nor referent power shows significant

difference between Norway and Finland. Legitimate is the power which a leader has by virtue of his position; leadership style is important factor in determining which way this power is used. This is a typical hard value while referent power is defined as a soft value because of its informality which comes from the personal characteristics of the leader. This power is depends on the co-workers and subordinates and to which extent they respect them and stay loyal towards them. (Brown, Lusch & Nicholson 1995; George & Gareth 2006.)

Table 9. Legitimate and referent power

Factor	Nationality	Respondents	Mean	Std. Deviation	Significance
Power Legitimate	Norway	87	4.1111	.91593	.637
	Finland	42	4.0317	.84202	
Power Referent	Norway	86	3.6473	.83604	.988
	Finland	39	3.6496	.68377	

The mean indicates that the use of these powers is not significantly different in the countries while the standard deviation implies that there are larger differences between the leaders within each country, or more correctly a difference in how the employees perceive the usage of these powers, within each of the hospitals.

As one of the informants said; *“Well, there are no orders... it is a very including leadership method we are using”* (Norwegian informant).

This implying that there is a very flat structure within the health care sector in Norway, and as shown by these results Finland the structure there is neither one that induces vertigo.

5.1.5. Expert power and consideration in leadership

Table 10 shows that expert power is not significant difference between Finland and Norway. However scores on leadership style shows significant differences on a 10% level. This is a power based on the special knowledge and skills which the leader incorporates (Gaski 1986; George & Gareth 2006). This power is in this thesis referred to as a neutral power, in that it can be used as both a hard and a soft value power. The findings in the statistical data are that there is little difference in the mean between the countries, but the standard deviation shows a higher difference of the answers in Finland than in Norway. The findings are not statistically significant, but do imply a less uniform opinion in Vaasa hospital and Ålesund hospital. None of the informants in the interview told me that they used this power, meaning that it is probably a power which is natural. Especially in a hospital most of the employees have quite some time spent in college and/or university this power seems to be a given.

Table 10. Expert power and consideration in leadership

Factor	Nationality	Respondents	Mean	Std. Deviation	Significance
Power Expert	Norway	88	4.7538	.60962	.491
	Finland	42	4.8492	.95197	
Leadership style (Consideration)	Norway	88	4.8977	.65284	.071
	Finland	42	4.6667	.72134	

A considerate leader is important and as such it is a trait used by managers which can be used to increase efficiency by reducing turnover, increasing confidence at work (for employees) and raise wellbeing at work in general. Therefore this is considered a soft value tool which a manager possesses (or not) (Lucas et al. 1987; George & Gareth 2006). The answers here are also not statistically significant on a 5% level, since there is only a 0.231 difference, and the standard deviation is no more than .07 in difference. This indicates that the leaders in both countries have a high degree of consideration.

5.1.6. Trust in manager

Table 11 shows a non significant difference in scores on trust in manager between Norway and Finland. This factor is based on the level of trust the employees have in their leader, and their leadership. This factor is based on how they perceive the integrity and their sense of loyalty (Rich 1997). The mean of both countries show that there is a high level of trust in the managers because of the general high score. The standard deviation in this data is almost identical implying that the difference in opinion between the hospitals in different countries is negligible or close none existing. When also including interviews from informants this factor is shown working both ways, from the employees to their leader, and vice versa. When asked if they trust their employees the informants replied:

Table 11. Trust in manager

Factor	Nationality	Respondents	Mean	Std. Deviation	Significance
Trust in manager	Norway	87	4.7816	.65792	.355
	Finland	42	4.6667	.65951	

"I highly trust them, I do not go in and do micromanagement, I trust my employees! If there are any problems, something that does not work, I go to the employee in question" (Norwegian informant).

"Very much! I just have to say that... I trust the entirety. Each of them has been handpicked from the position and they are very good within their field. They are incredibly loyal to what is decided and ratified, so I just have to say that I have a very high level of trust towards my employees... these middle managers control their units exceptionally well... so it's up to what you define as micromanage..... I might do that when I require feedback from employees, then I might be very detailed. But in everyday work, no. I think that has to do with the fact that I trust my employees so much" (Norwegian informant).

These are the answers from the Norwegian informants, as well as the two other informants in Norway stating that they trust their employees "100%" (Norwegian informant) as well as "*I trust them, There is so many people here with a high level of*

competences in their field, so I have every reason to trust them”(Norwegian Informant).

The Finnish informants had for most sake the same level of trust in their employees as stated by *”I trust them very much! They know what they are doing”* stating a complete trust in their employees and in their abilities.

”I trust them implicitly! I think that you have to trust your employees, I don't guard them and play big brother with them, we have a lot of strategy meetings, and I expect them to follow this, and unless they do something special I do not put my nose into the details, I believe I can trust them because there has never been any surprises from them, but you never know if it might come.”(Finnish informant).

Like the first Finnish informant, the second quote shows a complete trust in the willingness of their employees to work and in the abilities and skills of their employees. However we also talked about a possible corruption case at the hospital within the political side of the hospital, and the informant said explicitly that:

“Maybe you have heard something today? Yes, I read about a person being charged with corruption. [Someone in the political part of the hospital stole resources, or so it is claimed] Yes that was a big surprise, but ordinary employees do not have the possibility to do that, if you take my nurses I trust that they do their job to the best of their ability.”(Finnish informant).

This means that the informant did not have complete trust in their own leaders, but rather a complete trust in their employees which was what the question was intended to measure.

”I trust the ward nurses, but when you have such a large department, there will always be some people that don't work as well as others. But I trust that they do their best, and that my middle managers will tell me if there is a problem.”(Finnish informant).

This informant has a high level of trust in their employees, and she trusts that the people will work to the best of their abilities, which is the most anyone can expect from another person.

”I trust most of them... most of Finnish people want to work hard and to do their best, but some people who have some problems, own issues, or had for long times. There are so many people in my area, that it's hard to know everyone. But it takes very little time if anyone is not doing their job before I know about it.”(Finnish informant).

The last quote from Finnish informants shows a high level of trust, but not a complete

trust, however it is stated that it does not take long before a person not doing their job properly is uncovered.

5.1.7. McGregor's theory: findings

Table 12 shows a highly significant difference in the scores on McGregor's theory between Norway and Finland (significance = .001). McGregor's theory X and theory Y can be explained as X being where men are lazy and do not want to work and therefore constant supervision is needed, while theory Y is characterized by wanting to work to achieve goals, and that employees are creative and have the intellectual potential to reach set goals without supervision (McGregor 1985: 33–34, 47–48). The findings in the statistical data is significantly different between the two hospitals, however both countries accept McGregor's theory Y and refuse theory X as shown by an answer of 5 (out of 6) towards theory Y. The standard deviation is quite uniform between the countries, even if Norwegian answers 0.37 higher in mean than in Finland. The informants corroborate these findings:

Table 12. McGregor's theory X-Y

Factor	Nationality	Respondents	Mean	Std. Deviation	Significance
McGregor's theory	Norway	88	5.3835	.58101	.001
	Finland	42	5.0119	.61474	

”Most of them work well with goals, but some of the young doctors have to be micromanaged until they learn the ropes of how it all works here. But most of them you can just say that this is the goal, and they will reach it” (Finnish informant).

”If you’re a leader in a competence business you have give a very clear “frame” and full freedom within the “frame” when the goal is defined” (Norwegian informant).

These two quotes are examples of theory Y thinking, where there is a lot of freedom to reach the goals. Just as one of the informants said;”*full freedom within the frame*”

(Norwegian informant), meaning that the frame is what sets what is allowed and not. So you can do what you need to do to reach the goal within the frame set, the frame can be budget, rules, regulation etc.

”No... I very rarely go in and start to micromanage, because I think that they should be able to plan their day and they are so much better than me on the clinical part of nursing, because I do not have the opportunities to be out there as much. So I trust them in how they plan their day in reaching the goals of the department, sometimes I have to go in and micromanage, but that is incredibly rare” (Norwegian Informant).

“Yes sometimes. Could you give an example? Sometimes, especially when we plan vacation I have to tell people what and when they can do it which can be frustrating” (Finnish informant).

“Well, there is no orders... it is a very including leadership method we are using” (Norwegian informant).

While these two quotes show a combination of both X and Y. Off course the previous statements cannot be totally Y or X, they are always a combination because they are extremes which cannot be implemented alone. To clarify the two statements above have a larger degree of theory X in the than the two previous ones. The findings within the data collected by the questionnaires imply that there is some difference between the two hospitals perception of McGregor's theory X and theory Y.

5.1.8. Work satisfaction

Table 13 shows a non significant difference in the score between Norway and Finland on a 5% level, however on a 10% level the difference is significant (significance = .082) This Factor consists of three questions, and is a measurement of an employees overall level of general satisfaction with the job (Rich 1997). The difference in mean is 0.22 not statistically significant, while the standard deviation in Finland is higher than Norway, implying that there is a higher level of satisfaction with the job in Ålesund hospital than in Vaasa hospital. This factor is for general satisfaction, and is therefore not specific in what is good or bad. In chapter 5.1.9 there are three factors instead of one general one to specify in which way employees are satisfied with their work.

Table 13. Work satisfaction

Factor	Nationality	Respondents	Mean	Std. Deviation	Significance
Work satisfaction	Norway	88	5.2159	.62113	.082
	Finland	40	4.9917	.77160	

5.1.9. Work climate (autonomy, motivation, adaptation)

None of the above factors show any significant difference in scores between Norway and Finland. These factors are from the book *First, Break All the Rules* (Buckingham et al. 1999) and focus on the wellbeing of the employees. There should be at least a score of 4 which implies a generally satisfactory level of wellbeing at work. The mean value in table 14 indicates that there is a general level of wellbeing above 4 in both countries and hospitals. The data also indicates that there is only a minor difference between each hospital and in such no significant difference of wellbeing at work.

Table 14. Work climate (autonomy, motivation, adaptation)

Factor	Nationality	Respondents	Mean	Std. Deviation	Significance
Work climate "autonomy"	Norway	88	4.9489	.60310	.217
	Finland	42	4.8155	.50624	
Work climate "motivation"	Norway	84	4.1220	.93339	.886
	Finland	41	4.0976	.81754	
Work climate "Work Adaptation"	Norway	88	4.2670	.80925	.193
	Finland	42	4.4643	.79167	

Work climate autonomy is where the highest mean is located, meaning that there is at high level (almost 5 out of 6) autonomy within each hospital. This meaning that there enough equipment to do the job which they have to do as well as what is expected of

them. This also indicates very little micromanagement in the hospitals and more exact the departments that were asked.

Well I almost never micromanage... these middle managers control their units exceptionally well... so it's up to what you define as micromanage..... I might do that when I require feedback from employees, then I might be very detailed. But in everyday work, no. I think that has to do with the fact that I trust my employees so much (Norwegian informant).

“Most of them work well with goals, but some of the young doctors have to be micromanaged until they learn the ropes of how it all works here. But most of them you can just say that this is the goal, and they will reach it” (Finnish Informant).

Work climate motivation is the second factor which comes from the book *First, Break All the Rules* (Buckingham et al. 1999). This factor measures the recognition the employees feel that they get for their work. This also measures consideration at work, from fellow employees, but more specific from their leaders/managers. This is the same scale as with autonomy, where 4 or above means that it is satisfactory. The findings indicate that there is enough motivation within each hospital, and that the difference is not statistically significant. The standard deviation is quite similar and therefore not a factor which this thesis considers important. However as the data suggests this is the lowest mean of the three, and thus meaning that this is where the employees feel that there is a lack of motivation at work.

Work climate adaptation is the third and last factor from the book *First, Break All the Rules* (Buckingham & Coffman 1999). This factor focuses on friends at the workplace, and other social aspects of the workplace. The mean is not statistically significant, but does indicate a higher level of adaptation to the workplace in Vaasa than in Ålesund. However, this is the only one of the three which is higher at the hospital in Vaasa. The standard deviation is almost identical meaning that there is about the same spread answers in both Ålesund and Vaasa.

5.1.10. Total quantitative data

The data in figure 5 indicates that hospitals leaders in Norway and Finland have similar values, there is very little difference between the managerial power factors, and to

which extent they are used. What I find most interesting is indicated in the factors, coercive power, reward power and McGregor's X and Y. In addition there is a large difference in the Money and Time factor.

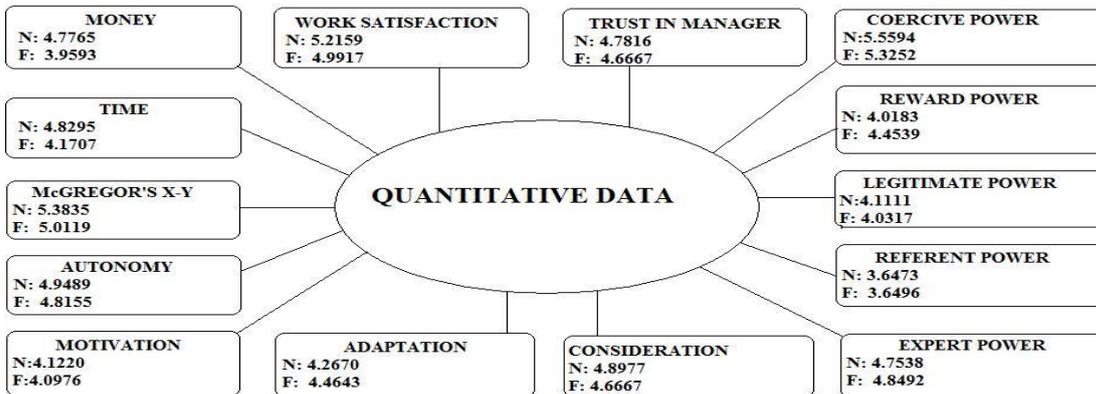


Figure 5. Total quantitative data; mean on factors/scales in Norway and Finland.

5.2. Qualitative research

The quantitative research is the focus of the second part of this chapter, and will focus exclusively on the 8 interviews done. Four of these are from leaders at Ålesund hospital in Norway, while another 4 are from leaders at Vaasa hospital. The questions which are used are in appendix 1.

The experience of the informants is between 6 and 25 years. The longest experience of my informants is in Finland, however the average age among the personnel and managerial staff was higher in Finland, at least one of the Finnish informants told me that there was a problem with getting new nurses because so many were retiring and too few educated to fill up the void created by this.

Table 15.

Empirical findings

Informant	N-1	N-2	N-3	N-4	F-1	F-2	F-3	F-4
Resources	A	A	A	A	G	A	A	L
Communication	G	A	G	A	G	G	A	A
Leader experience	17yrs	18yrs	6yrs	15yrs	25yrs	19yrs	20yrs	12yrs
Education	6yrs	6yrs	5yrs	8yrs	7yrs	5yrs	8yrs	7yrs
Personnel	L	A	L	L	A	A	L	L
Clear Goal	G	G	G	G	G	G	G	G
Paperwork time spent	100,0 0%	50,00 %	70,00 %	50,00 %	60,00 %	50,00 %	50,00 %	70,00 %
Trust	G	G	G	G	G	G	G	G

Legend: L= Lacking A = Adequate G = Good N=Norwegian F= Finnish

5.2.1. Experience, Education and Resources

“A lot of people retire, and education of new people is low. There will be more nurses retiring than new nurses educated. We have two schools here, the Swedish and the Finnish one, so it’s probably easier here than in other parts of the country. The nurses are also more mobile now, which they were not before. Earlier nurses stayed where they were educated. They can get work almost anywhere, but it’s a challenge to get them to enjoy and stay” (Finnish informant).

“We have enough money, but we do not have enough doctors. In summer we have problems with nurses as well, because of the vacations. In summer the situation is bad, but we have money at least...” (Finnish informant).

“There has always been some lack in specialized doctors, so I have had to fill in often. And now I have the least doctors I have ever had. It has always been cut backs since I got a management position, every year. A lot of prioritizing is needed.... I think we have to get more resources, but I think the only way for us to get more is to work more efficiently, and that more people will like to work here, especially doctors, because money is not the main problem, doctors are” (Finnish Informant).

The lack of personnel is a Vaasa and by extension in Finland as said by the statement

above, even if this is not a problem at present it will be when large number of nurses retire in a few years time. Another difficulty is that a lot of doctors are moving to Private practice, leaving the public health care understaffed. There does not seem to be a lack of money at the hospital of Vaasa, but rather a problem of hiring personnel to the public health care sector. The lack of personnel is not dangerous at present, but according to statements they could become dangerous in the future unless something is done to increase the acquiring of more staff.

“A lot of these people go to private practice, so they have more control over their workload. In the long run we will lose doctors abroad unless the burden on each doctor is not lightened at this department. But for now it is not that bad, but I worry about the future” (Finnish informant).

However there are some difficulties with personnel in Norway as well, but not relating to retirements. Several Norwegian informants state that there is a distribution problem in Norwegian health care “The resource problem is quite common within the hospital.” (Norwegian informant)

“There is no resource problem in Norwegian health care, but rather a distribution problem, and this is because the logical restructuring that should be done in accordance with Qualitative reasoning cannot be done, since the sector is controlled by politics” (Norwegian informant).

“The resource situation is at times not good enough, but it is not enough to say that we have to little resources, that is too easy. It has also something to do with how we manage to organize ourselves here at this unit, and if you should say that that is missing competences, you could say that that is also a resource. Maybe the main reason we cannot reach the goals, the times we don't do it. Then it is lack resources, either doctors or nurses, I think I have to say that as the main reason” (Norwegian informant).

“It is very dynamic at this department. However, in busy periods, with lots of patients, or with what we call”heavy” patients... Patients that require a lot of attention. Then the staff is less willing to take extra shifts because they get tired and worn out more quickly, and we also see a small rise in sick leave of the staff. So when we require more resources, we see that the resource situation falls because of too much pressure on the staff, while in periods of lower intensity it is more the opposite. The staff wants to work more, so they almost argue of who can take the extra shifts” (Norwegian informant).

“uh... That is what might be the problem... that's maybe quite hard... there are continuously more and more tasks we need to do and we see that especially within treatment where there are constantly new treatments that we need to relate to and make decisions about. To do that requires more people, but at present we have enough people to do the tasks that's needs to be done, at least the ones that have been a priority” (Norwegian informant).

At the Hospital of Ålesund compared to Vaasa hospital, there does not seem to be a

particular lack of funding for operations of the departments, but as one informant states they have to do more tasks with the same or sometimes less funding than before, leading to prioritizing tasks. However at times there can be both a lack of Funding and off staff because of overwork leading to sick leave. There does however seem to be a greater lack of funding at Ålesund hospital, than at Vaasa Hospital. At Vaasa hospital a lack of personnel seems to be of greater worry for the leaders (off course they would not say no to more money, but who would?!). The same is true in at the hospital of Vaasa as stated by a Finnish informant, however it was not especially sick leave she referred to but rather the loss of personnel, especially doctors to the private sector health care. In Norway this loss to the private sector is almost none existing, since the total of the private sector health care is public, although private health care is increasing in Norway (Helse midt-Norge 2009).

5.2.2. Communication, Orders, Goals and “Quality”

Orders are the means of making employees do their tasks, but is it necessary? There seems to be little use for orders, because of the hospital business being a “Competence business”.

“Well, there are no orders... it is a very including leadership method we are using...[Sic]...If you're a leader in a competence business you have give a very clear “frame” and full freedom within the “frame” when the goal is defined” (Norwegian Informant).

There is seems to be a strong connection between orders and trust. The higher the trust from the manager to the employees, the less strictly orders are given. The employees will in that case work more autonomous, and since all the informants expressed a high level of trust in their employees (table 3.11) there seems to be a high level of autonomy within the departments which my informants works in.

“Most of them work well with goals, but some of the young doctors have to be micromanaged until they learn the ropes of how it all works here. But most of them you can just say that this is the goal, and they will reach it” (Finnish Informant).

The communication within a department, as well as the inter department communication and the administrations communication is of vital importance to create a

good environment at work and to make efficient decisions.

“...Communication is a very large area, so you could break it down to greeting each other in the morning, both verbally and non-verbally, but it is a challenge for me as a leader here. The communication to the subordinates, when you think about everything that is needed to be communicated, the information that is to be sent to the employees. I sometimes feel a lack of such communication... in getting that communication to them, that the communication to them does not always become as good as I had wished... [Sic]... I don't think it works well. They.... if that has with them almost all being women, today there is only women working here (except me), there is sometimes a man that's takes an extra shift here... but... if you see what it said over there at the desk "talk to me, not about me"...[Sic]... If there is something they do not approve of that I have done, or not done they rather sit in the break room and talk about it than to come and talk to me about it, that is a bad habit which is in the department, and the assistant department head, she said that it is a kind of pleasure with disapproval... like it is a bit "nice" to have it not that good and talk about it. So instead of talking to me about it, they go silent when I come into the break room. That is a challenge that we are going to work with come New Year" (Norwegian informant).

This informant is in charge of one ward, and as such does differ from the three other informants at the hospital of Ålesund. He is what is referred to as a middle manager, and as such he has more direct contact with the employees at the "factory floor" if you will. He describes that there are some problems when communicating to the subordinates. It seems that the informant is more cut off from social interaction with his subordinates than those in higher positions, even if he needs to have more social interaction with them than those further up in the hierarchy.

“...almost all communication here is two way communications. I never have the door to my office closed, unless I am having a conversation which requires it. So the door is open, because it «tells» something about my availability” (Norwegian informant).

The second quotation is from a high level manager, who seems to have a completely different experience, even if in principle it is the same approach as the previous one. There is only one difference between these two, and that is gender. This is probably not the norm, however gender and hospital value management would be an interesting continuation of this research. The statistical data on male/female differences is added in appendix 3. The informants at the hospital of Vaasa were all female, so in this qualitative/quantitative research there is no information on the qualitative side on the difference between these two hospitals. The informants on communication at the hospital of Vaasa gave little information about personal feelings, and were more concerned with the structure of this communication. Furthermore the information they gave there is an expression of lack of time due to ill prepared meetings, which are due

to take place regularly at different intervals, ranging from once a week, to one three times per 6 months.

“...but what takes the most time is all these meetings, that you have to be in. I feel I have no way of making a difference in these meetings. I feel that they are poorly planned and in most cases waste a lot of time” (Finnish informant).

This of course referring to time spent both planning and the execution of the meetings. This is also considered by several of the informants as “paperwork”, administrative work which makes time to do other things, like clinical work, hard to find.

I usually don't do it all once it gets here because then I would never get anything done. There's also a lot of time spent on meetings, 50% is paperwork, and in bad times with lots of meetings at least 70% is used on “paperwork” (Finnish informant).

When asked if the goals put to them were clear, there was a unanimous yes from all informants. The problem on the other hand was the resources to reach these goals. This lack leads to prioritizing which goals to achieve and which not to waste resources on; this was perhaps most clearly expressed in Finland when asked if they felt that the current resource situation was good enough to reach these goals. This statement was from an informant at the psychological department.

“I think we have to get more resources, but I think the only way for us to get more is to work more efficiently, and that more people will like to work here, especially doctors, because money is not the main problem, doctors are. There are a lot of people who burn out, and retire early and get problems from overwork...[Sic]...In the long run we will lose doctors abroad unless the burden on each doctor is not lightened at this department. But for now it is not that bad, but I worry about the future” (Finnish informant).

The difficulty with resources and goals is a problem at both hospitals, as a Norwegian informer told me when asked about resources

“...here are continuously more and more tasks we need to do...To do that requires more people, but at present...we have enough people to do the tasks that's needs to be done, at least the ones that have been a priority” (Norwegian informant).

While the goals are clear, there seems to be a lack in certain departments of resources to reach these goals. This is true both at the hospital of Vaasa and the hospital of Ålesund. However the informants interviewed expressed a larger difference in resource distribution at Vaasa hospital compared to Ålesund hospital. The most interesting

interview about the resource situation was with a Norwegian informant who expressed his views on how he felt the structure should change because of the lack of flexibility and planning which the centralization in the Norwegian health care had led to.

“We have almost 120 people employed at this department, and a budget of about 70 000 000 NOK (which is about 8,3 million Euro), so I really wish I had an administrative team around me. Most of these functions are at the (hospital) administration now, but they should have been localized (for my department) here. So more support to you here so that you could do other things than (paperwork)? Yeah, and that there would be shorter... now a lot of time is wasted with repeated contacts to the administration, and the administration who has to deal with a lot of different departments. When I worked outside the hospital it was natural that these functions, such as economy, secretary and others were directly linked with the leader [of each department]. So you feel that your overloading with so many functions based on yourself? That is right, so that I also become the coordinating link towards the (hospital) administration here. I wish we had more freedom and more personnel available here at the department. The personnel control is two sided, with one dealing with the department needs, and the rest with the whole of the administration needs. We should have had every function at the department level so that we could plan for month to month and then changed it into an analytical function and then we should have meetings with the administration who would deal with the whole of the hospital rather than individual departments. So you wish that the administration would give your department the resources and rather let you use them in accordance with the needs? Yes, I'm sure we could save resources doing it like this. Now there are cut backs, in the private they do not have this issue because the stock owners expect a return from their investment.... but I think that we in the public should have more freedom at department level“ (Norwegian informant).

This informant seems to have a good overview of his department and the needs; this may come from experiences outside the hospital in the private sector. The administrative part of working at his department is taking up to much of his time, and at the same time making the work more time consuming than necessary.

6. CONCLUSIONS

The goals for this thesis was to find *to what extent are Norwegian and Finnish hospitals different in relations to the hardness and softness of managerial values? And is this possible difference in managerial values affecting the management of Ålesund and Vaasa hospital and in [if it does], in what way?* The case study was a two edged sword, on the one side a survey, using questionnaires with the employees, while interviewing the managers of these employees. After collecting both quantitative and qualitative data, then compare the two hospitals as to there were any significant difference in the way they were managed. This was to be found through Managerial powers, leadership style as well as McGregor's theory X and Y. While this thesis has found certain differences in managerial power used, it was not any large difference, According to Hofstede's indexes there would not be any great lead in difference, other than in MAS index (see table 1). Following this one found if the difference of efficiency was actually due to different values in the leaders, or if this was due to something other than Values.

The basis was the single department, where the managers would be interviewed while the employees would answer a survey. The exposing of these values would then give a basis to compare the value sets which each of the hospitals managers had. While efficiency wise, the hospital of Vaasa is more efficient, with spending, about 30-40% less money per patient. I wanted to know if this was due to the fact that Finland had harder values, meaning more focused on efficiency, rather than work satisfaction and time spent on patients. Hofstede's MAS index indicated that there would be more feminine values in Norway; there are softer values in Norway, but not to the extent to which the index indicates. A difference of almost 20 points on the MAS index should be much clearer than the findings this thesis acquired through the survey and interviews.

6.1. Main findings

Table 16 shows the main findings, first of the main question was answered to which extent there was a difference in the hardness and softness of the managerial values as is shown in the table. They were both on the softer side of the spectrum, even though Norway is a little softer than Finland. The managerial power factors which suggest that managers in Finland tend to use both reward and coercive aspects of power more often. In other words using more of both hard and soft values. In Norway they seem to focus on less use of the hard powers, rather than using soft powers. This difference in hardness and softness does affect the managerial staff. At the hospital of Ålesund they tend to not use soft power while ignoring the hard value powers as well, this off course does not mean that they do not use power. They just use less hard power, so this indicates that the power structure at the hospital of Ålesund is flatter than the one at the hospital of Vaasa. This is according to Hofstede's indexes more likely to happen in a country with a low level of MAS index than in one with a higher value. One Norwegian informant also explained that there were no orders in his department, that it was a very including leadership method which they were using, and that one had to give full freedom within set frames to bring out the best in people. This is classical McGregor's theory Y thinking. Orders are used to a higher degree at the hospital of Vaasa than at Ålesund hospital, but the difference is quite small. The seemingly flatter structure at the hospital of Ålesund makes the ordering of employees less of a task. The second question was not as easy to answer, and there are just a few indications about what this difference in hardness and softness does. This will be further explored in chapter 6.1.1. and 6.1.2.

Table 16. Main findings

	Harder Values <-----							----->Softer Values										
Quantitative Score	2,6	2,8	3	3,2	3,4	3,6	3,8	4	4,2	4,4	4,6	4,8	5	5,2	5,4			
McGregor's Theory X-Y													F		N			
Work Satisfaction													F	N				
Managerial Power												NF						
Trust in manager											F	N						
Autonomy												F	N					
Qualitative Score	Lacking-----							-----Adequate-----				-----Good						
Personnel	F		N															
Money/Time								N		F								
Communication													N		F			
Trust in employees																	F N	
Autonomy													F		N			
Usage	Low <----->High																	
Orders	N		F															

Legend: N = Norway F = Finland (4 or above equals acceptance, on the scale on 1-6, 1 to 3 is negative , while 4 or above is of positive)

6.1.1. Powers and McGregor

The powers used imply that there is a lower usage of reward power at the hospital of Ålesund compared to in Vaasa, while coercive power indicates the opposite. This indicating that there is a lack of possibilities to use certain powers. Either by will of the managers, that the managers at the hospital of Vaasa give more rewards, but are stricter

and tend to use coercive power more often. On the other hand, at the hospital of Ålesund managers give less reward, but are also less likely to use coercive power to get something done. Legitimate and referent power shows little difference, indicating that these two powers are in equal use at both hospitals, meaning that further study is required to show if there is any significance (which was not found in this thesis).

Expert power is indicated as stronger in Finland than in Norway, while a manager's style of leading the employees is thought of as more considerate in Norway. When considering the factors, with equal importance Norway does seem to be more towards soft values, but not as much as Hofstede's MAS index indicates (26 versus 8). McGregor's theory X and Y has above a level of 4 (which means acceptance of theory Y). However, at the hospital of Ålesund, there is a higher level of acceptance of theory Y than in Finland. Theory Y is considered soft in this thesis (while theory X is hard), and thus meaning that in the powers used as well as McGregor's theory X and Y, Ålesund hospital has a softer values than at the hospital of Vaasa, even though the difference is quite marginal. The differences found in the theory X and Y part of the statistical data are not certain, but the significance indicates that these findings are valid. In other words these findings imply that there are softer values in Norway than in Finland. However the Empirical data do not corroborate this, or falsify this. All informants showed a high level of understanding communication and the importance of communication. According to Macgregor's theory X and Y the findings fall in line with the fact that theory Y is the commonly accepted theory this day in age.

6.1.2. Work satisfaction and recruitment

The statistical findings are how the employees experience their superiors, and in such give a picture of how they perceive their workplace. This leads me to the findings in work satisfaction. There are 4 factors, and of these the general satisfaction with work is higher at the hospital of Ålesund than at the hospital of Vaasa, motivation is higher and Autonomy as well. Adaptation is higher at the hospital of Vaasa indicating that the joy of working at their hospital is in general higher at Ålesund hospital than Vaasa, but that the personnel at Vaasa hospital find it easier to change work conditions than in Ålesund.

The difference in managerial values which in Finland is a fraction harder than Norway seems to lead to lower work satisfaction, in general. However, there was little or no direct dissatisfaction within those departments asked in the questionnaire, although it was less satisfaction than within those asked in Ålesund.

There seems to be a higher degree of autonomy within the hospital of Ålesund, than in at the hospital of Vaasa, this shown both in the qualitative and quantitative data. Autonomy is a part of the larger satisfaction factor (consisting of motivation, adaptation and autonomy). The difference is minor, but if one looks at this in comparison with the work satisfaction, one can see how this influences. Adaptation which Finland scores the highest of seems to influence less on satisfaction at work. However, both countries score a relatively high score on work satisfaction.

The resource shortage is indicated to be more uneven than in Norway however, with certain parts of the hospital lacking funding, but more importantly personnel. In Ålesund the lack of funding seems to be even in all departments, but less serious than in the departments with lacking funds at the hospital of Vaasa. All in all the hospital in Ålesund works well with the resources they have, even if there is less resources available since the hospital reform of 2001 (Hagen & Kaarbøe: 2006). This because of a refocus of money from the smaller hospitals to the larger university hospital in Trondheim (Sjursen 2008).

Even so the funding at most the informants departments at the hospital of Vaasa seemed adequate, but there seemed to be a lack of personnel rather than money. According to the quantitative study Norwegians had a higher score in both money and time, meaning that they would like more of both. In other words, what the finding implies is that money seems to be more of a problem in Norway than in Finland, and this is quite probable because of the structure of the health care sector. Since the change in Norwegian health care sector of 2002 the system has been centralized to a greater extent, and thus losing flexibility to use the resources available at the micro level. In Finland they have a De-centralized system in the Health care sector, and this seems to be working better at a local level than in Norway.

This thesis concludes that there are softer values at the hospital of Ålesund, compared to the hospital of Vaasa. This on basis of both questionnaire and in the interviews. This fits with Hofstede's MAS index. The thesis also concludes that the hospital of Vaasa is more efficient with its resources, most likely caused by the structure of the system in which at a local level the hospital is more flexible due to its decentralized structure. There is no doubt about the efficiency of the Finnish health care sector, but the findings indicate that this comes with a possible price. The price is a lower work satisfaction, possibly resulting in problems recruitment of personnel, especially clinical personnel like doctors and nurses.

6.2. Limitations and cultural bias

There is a possibility that because of lack of language skills that the interviews in Finland are themselves flawed because of wrong interpretation by either party of question or answer. Lack of language skills on either side can lead to misinterpretations, and as such possibly to wrong conclusions. There is also a possibility that I since being Norwegian interpret both the statistical data or the empirical data in a certain way that fits with my own world view, this has always been a problem for scientists, and I do not think that, even if it has not been deliberate, can say not has affected me. I have tried to minimize this, but there is always some sort of cultural or national bias involved in this thesis. I myself have experience from the hospital in Ålesund, being a patient there for two months. This may have lead to a certain bias, even if I have tried not to let it interfere with the science

Hofstede's empirical evidence is around 40 years old, and there has been an enormous development in both Norway and Finland in that period. The empirical data was also taken from the capital of each country, and as Håvold (2007) mentioned the findings of the same scale but in other parts of the country was much higher than in the biggest city. It is therefore quite reasonable to assume that this is also true for Finland, and especially with the development over the last decades that the MAS index is not the same in Vaasa

as it was in Helsinki in 1960s and 70s.

6.3. Further research

There can be several reasons for this; one is that Hofstede's MAS index was taken in the capitol cities of each country, meaning that they are for Oslo and Helsinki. In Håvold's thesis of 2007 he found that people from Norway's western coast and from the northern part had a higher MAS index than those in Hofstede's MAS index. Vaasa is a bilingual city with a large minority of Swedish speaking Finns. Sweden has 5 on Hofstede's MAS index (1997: 84), which is lower than Norway's MAS index, and considerably lower than Finland's MAS index. This implies that the Swedish culture has a larger influence on this part of Finland than of Helsinki. Most likely the result is a difference in the local culture of each country that lead to this almost insignificant difference in soft and hard values. It is therefore more likely that the difference of efficiency which is indicated by the financial statements of each hospital is of structural origin, and that the difference will be more accurately found within this sphere of research.

The same is true for the theory X and Y factor; the basis the statistical evidence is too narrow for this to be a certainty. One should have a larger group, with the same questions, and preferably in both Swedish and Finnish. Since in this thesis' the questionnaires for the hospital of Vaasa were only in Finnish there was a problem approaching Swedish speaking personnel with them. There is therefore a lack of respondents on the Finnish side. There were only about half the respondents of the hospital of Ålesund. The work satisfaction seems to be statistically viable and as such is considered statistically significant. However, it should be pointed out that the basis of this statistical data is the same as the previous, and as such has half the respondents as the data for the hospital of Ålesund.

There is extra statistical material in the appendixes which may be interesting to explore further. I found more similarities among informants, on the basis of gender, than on the basis of nationality. The statistics also indicate that this would be an interesting way to

progress on this study. There is also statistical information of the difference of opinions between those that have a leader function in their job, compared to those that do not. This would also be interesting to explore and gather more data about.

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APPENDIX 1. Interviews

These are the question used in the interviews not including follow up questions.

- What education and experience did you have before you were hired at your current position?
- How long have you had a position where you have been a leader?
- How long have you had your current position?
- How do you feel your current resource situation is? How do you feel this affects you?
- How do you control your subordinates? In what way are orders / goals informed to your employees?
- Could you explain the goal of your organization and of your department?
- Do you have enough resources to reach this goal?
- To which extent do you trust your employees?
- Do you need to micromanage your employees or are they autonomous?
- How does the communication in your department work?
- Do you spend a lot of time on "paperwork", in any case how much of your time is used on paperwork?

APPENDIX 2. Questionnaires

- 1 Gender?
- 2 What is your age?
- 3 Total years of education
- 4 What is your nationality?
- 5 How long have you worked within the health care sector?
- 6 In what department do you now work ?
- 7 Management position?
- 8 What is your current position?

At your workplace: To which extent do **you** agree with the following statements?

(1-6 points) Strongly disagree |Disagree|Somewhat Disagree| Somewhat Agree|Agree|Strongly Agree

- 9 More money is better
- 10 Money is not an issue
- 11 Money make decisions easier
- 12 More time is better
- 13 Time is not an issue
- 14 Time make decisions easier
- 15 My leader would get back at me if I did not do as he\she asked
- 16 My leader often hint that he would take action that would reduce my pay if I did not go along with his requests
- 17 If I did not agree with my leader he\she can make life difficult for me
- 18 My leader is an expert in his field
- 19 I respect the judgment of my leader
- 20 I get good advice from my leader
- 21 I have an obligation to do what my leader wants
- 22 Since he\she is my leader, I accept his recommendations
- 23 It is my duty to do as my leader requests
- 24 I really admire the way my leader runs his «department», so I try to follow his lead.
- 25 I generally want to operate very similar to the way I feel my leader would
- 26 I am proud to be affiliated with my leader.
- 27 My leader gives credits where credits is due
- 28 My leader recognizes achievements
- 29 My leader rewards good work
- 30 My leader promotes those who deserve it
- 31 Most employees can't be trusted.
- 32 Most employees will not exercise self-control and self-motivation – managers must do this for them.
- 33 Most people are lazy and don't want to work.

- 34 Most employees have little ambition.
- 35 There is a good working relationship between the employees and the manager
- 36 Our manager does a good job of providing help with difficult or complex work problems.
- 37 All in all, I'm satisfied with my job
- 38 In general, I like working at my company
- 39 In general, I don't like my job
- 40 My manager would never try to gain an advantage by deceiving workers
- 41 I feel a strong loyalty to my manager
- 42 I have complete faith in the integrity of my manager
- 43 I feel quite confident that my manager will always try to treat me fairly
- 44 I have strong sense of loyalty toward my manager
- 45 I know what is expected of me?
- 46 I have the materials and equipment I need to do my work right?
- 47 I have the opportunity to do what I do best every day?
- 48 In the last seven days, have I received recognition or praise for doing good work?
- 49 My supervisor or someone at work seems to care about me as a person?
- 50 There is someone at work that encourages my development?
- 51 My opinions seem to count?
- 52 The mission/purpose of my company makes me feel my job is important?
- 53 My co-workers are committed to do quality work?
- 54 I have a best friend at work?
- 55 In the last six months, someone at work has talked to me about my progress?
- 56 This last year, I have had the opportunity at work to learn and grow?

APPENDIX 3. Factor and country

Factor	Nationality	Respondents	Mean	Std. Deviation	Significance
Money	Norway	88	4.7765	.70343	.000
	Finland	41	3.9593	.92854	
Time	Norway	86	4.8295	.83821	.000
	Finland	41	4.1707	.65031	
Power Coercive	Norway	87	5.5594	.50449	.038
	Finland	41	5.3252	.73970	
Power Expert	Norway	88	4.7538	.60962	.491
	Finland	42	4.8492	.95197	
Power Legitimate	Norway	87	4.1111	.91593	.637
	Finland	42	4.0317	.84202	
Power Referent	Norway	86	3.6473	.83604	.988
	Finland	39	3.6496	.68377	
Power Reward	Norway	82	4.0183	.79716	.002
	Finland	38	4.4539	.43049	
McGregor's theory	Norway	88	5.3835	.58101	.001
	Finland	42	5.0119	.61474	
Leadership style Consideration	Norway	88	4.8977	.65284	.071
	Finland	42	4.6667	.72134	
Work satisfaction	Norway	88	5.2159	.62113	.082
	Finland	40	4.9917	.77160	
Trust in manager	Norway	87	4.7816	.65792	.355
	Finland	42	4.6667	.65951	
Work climate "autonomy"	Norway	88	4.9489	.60310	.217
	Finland	42	4.8155	.50624	
Work climate "motivation"	Norway	84	4.1220	.93339	.886
	Finland	41	4.0976	.81754	
Work climate "Adaptation"	Norway	88	4.2670	.80925	.193
	Finland	42	4.4643	.79167	

APPENDIX 4. Genders influence on factors

Factor	Gender	Respondents	Mean	Std. Deviation
Money	Male	23	4.7826	.72897
	Female	113	4.4838	.88078
Time	Male	22	4.7273	.88871
	Female	112	4.6250	.83723
Power Coercive	Male	23	5.4203	.69789
	Female	112	5.4792	.60160
Power Expert	Male	23	4.6667	.62765
	Female	114	4.7924	.78630
Power Legitimate	Male	23	3.7681	.91251
	Female	113	4.1357	.92328
Power Reference	Male	23	3.2899	.81838
	Female	109	3.7125	.80567
Power Reward	Male	23	4.1522	.66887
	Female	104	4.1683	.78087
McGregor theory	Male	23	5.2174	.75868
	Female	114	5.2566	.65637
Leadership style Consideration	Male	23	4.7174	.61839
	Female	114	4.8289	.76375
Work satisfaction	Male	23	5.1014	.55446
	Female	112	5.1726	.70460
Trust in manager	Male	23	4.5978	.61116
	Female	113	4.7677	.68605
Work climate "Autonomy"	Male	23	4.9348	.64057
	Female	114	4.9254	.56338
Work climate "Motivation"	Male	23	3.9348	.98054
	Female	109	4.1422	.87821
Work climate "Adaptation"	Male	23	4.2826	.87680
	Female	114	4.3553	.78064

APPENDIX 5. Leader functions influence on factors

Factor	Leader Function	Respondents	Mean	Std. Deviation
Money	Yes	29	4.1264	.94874
	No	103	4.6602	.79209
Time	Yes	30	4.4778	.82436
	No	100	4.7267	.82794
Power Coercive	Yes	30	5.5667	.48857
	No	101	5.4356	.65105
Power Expert	Yes	30	4.8222	.67656
	No	103	4.7443	.79102
Power Legitimate	Yes	30	4.0000	.79269
	No	102	4.1078	.94649
Power Reference	Yes	30	3.4778	.73596
	No	99	3.7037	.84635
Power Reward	Yes	27	4.3426	.73428
	No	97	4.1186	.77316
McGregor theory	Yes	30	5.2750	.61711
	No	103	5.2621	.67735
Leadership style Consideration	Yes	30	4.7000	.63788
	No	103	4.8398	.76765
Work satisfaction	Yes	30	5.2667	.47464
	No	101	5.1221	.72682
Trust in manager	Yes	30	4.6417	.73309
	No	102	4.7623	.65757
Work climate "autonomy"	Yes	30	4.9833	.54903
	No	103	4.9078	.59098
Work climate "motivation"	Yes	30	3.8500	.91114
	No	98	4.1913	.89587
Work climate "Adaptation"	Yes	30	4.2500	.80676
	No	103	4.3689	.77321

APPENDIX 6. Hofstede's indexes/dimensions of culture

Hofstede's (1997; 2001) original study is a product of attitude questionnaire surveys conducted world-wide in IBM subsidiaries. In his original work, he identified four key dimensions through factor analysis, which have an effect on natural cultural differences:

- *Individualism/collectivism*: This dimension reflects the extent to which individuals value self-determination, as opposed to their behavior being determined by the collective will of a group or organization.
- *Power-distance*: At the core of this dimension lies the question of involvement in decision-making. In low power-distance cultures, employees seek involvement and have a desire for a participative management style. At the other end of this scale, employees tend to work and behave in a particular way because they accept that they will be directed to do so by the hierarchy or the organization.
- *Uncertainty avoidance*: This dimension is concerned with employees' tolerance of ambiguity or uncertainty in their working environment. In cultures that have high uncertainty avoidance, employees will look for clearly defined, formal rules and conventions governing their behavior.
- *Masculinity/femininity*: In highly "masculine cultures" dominant values relate to assertiveness and material acquisition. In highly "feminine cultures" values focus on relationship among people, concern for others and quality of life.

Together with a colleague, Hofstede (1997; 2001) identified a fifth dimension as a result of two surveys among students from 10 and 23 countries respectively. This dimension was first termed "Confucian dynamism" and later renamed as "long-term orientation."

- *Long-term/short-term orientation*: Long-term orientation reflects a society that fosters virtues oriented towards persistence and perseverance, thrift, and that orders relationships by status and observes that order by having sense of shame. Short-term orientation reflects a society that fosters virtues of personal steadiness and stability, protecting face, respect for traditions and reciprocation of greetings, favors and gifts.