HOW DOES IMAGE ACCOMPANY STRUCTURE IN ORGANIZATIONS?

EXPLORING PROFESSIONALISM AND MANAGERIALISM IN THE ORGANIZATIONAL IMAGES OF SWEDISH HOSPITALS

Authors: Christoffer Aldin and Peter Lundqvist
Supervisor: Stefan Jonsson

ABSTRACT:
With the emergence of New Public Management in the 1980s, Western public sectors saw a gradual shift in logics of work control from professionalism to managerialism. For public sector organizations to attain legitimacy in this new climate, their organizational structures have been aligned according to extant societal expectations of managerialist efficiency. In addition to structure, organizations are also asked to have an organizational image that appeals to the same societal expectations if legitimacy is to be achieved. The pursuit of legitimacy is an aspect that connects image and structure but this has been neglected in previous research. Against this, the purpose of the present thesis is to explore whether and how changes in organizational image covariate positively with shifts in organizational structure. In order to investigate this, an organizational discourse analysis has been conducted on a sample of Swedish hospitals’ webpages in 2005 and 2013 as a way to learn more about the distribution of professionalism and managerialism in these entities’ images. The results indicate that the two logics of work control have increased between the studied years but managerialism displays a slightly bigger growth. Nevertheless, a blend of professionalism and managerialism is what is most apparent in the organizational images of the sampled hospitals in both 2005 and 2013. While previous literature has argued that organizational structures have shifted decisively towards managerialism, this thesis indicates that the change has been more nuanced when it comes to organizational images.

KEYWORDS: Organizational image; Organizational structure; Professionalism; Managerialism; New Public Management; Hospitals.
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1. Introduction
Starting in the 1980s, many Western countries gradually introduced private actors and business-inspired ideas into their public sectors (Blomgren, 2003; Scott et al., 2000). In the literature, these reforms came to be known under the umbrella label New Public Management (NPM) (Hood, 1991, 1995). According to Olson et al. (1998), the NPM reforms were initially set in motion by citizens’ concerns about the efficiency of their governments’ allocation of tax money. NPM meant that public organizations were introduced to a great deal of ideas about controlling and organizing that had previously only been used in the private sector (Power, 1997). By incorporating business influences and allowing the entrance of private firms into public sectors, politicians argued that NPM had the capacity of making public spending more efficient (Hood, 1995).

The hospital sector was no exception to these reforms. Historically, the organizational structure of hospitals had been characterized by the dominance of medical professions (Scott et al., 2000; Östergren & Sahlin-Andersson, 1998). Long education, extensive on-site training and command over bodies of tacit knowledge had traditionally legitimated the work of professionals in hospitals (Mintzberg, 1993). Therefore, medical professions had usually been allowed to assess their output without much external interference (Freidson, 2001). Such autonomous conditions of work control are denoted as the logic of professionalism (Blomgren & Waks, 2011). With the advent of NPM reforms, medical professions’ dominance in hospitals nevertheless came to be threatened (Blomgren & Waks, 2011; Levay & Waks, 2009).

As a response to calls for increased efficiency in public sectors, organizational structure in hospitals has since the 1980s gradually switched and come to be based upon the managerialism logic of work control (Evetts, 2003; Scott et al., 2000). Managerialism has its roots in the private sector and its main concern is the achievement of maximum efficiency with scarce resources (Kiechel, 2012). As a consequence of this movement from professionalism to managerialism, professionals’ work in hospitals is nowadays increasingly legitimated by business-inspired control and accountability mechanisms (Pollitt, 1993).

The shift from professionalism to managerialism as the new dominant logic of work control has affected the organizational structure of most hospitals in the Western world (Christensen & Lægreid, 2001). A neoinstitutional explanation to such change in structure would be that organizations in a field cannot diverge too much from their competitors due to social norms of and beliefs about appropriate organizational behavior (DiMaggio & Powell, 1983). By designing a structure that conforms to these norms and beliefs, an organization shows that it is acting “on collectively valued purposes” (Meyer & Rowan, 1977: 349) and ultimately attains legitimacy among the constituents in the environment (Oliver, 1991). In line with neoinstitutional arguments, Carvalho (2012) states that hospitals’ movement from professionalism to managerialism has been done as a means of appealing to prevailing demands for increased efficiency in public sectors.
In addition to organizational structure, many researchers have stated that organizational image is also a central concept in the achievement of legitimacy (Gioia et al., 2000; Hatch & Schultz, 2002; King & Whetten, 2008; Van Riel & Balmer, 1997; Whetten & Mackey, 2002). Scholars have argued that the shift from industrialism towards a service economy (Grönroos, 1984), the replacement of local businesses for global consumption patterns (Hertz, 2003) and the demands for social responsibility placed by interest groups on corporations (Alvesson, 1990) are three reasons for the increased salience of organizational images during the last three decades. According to Alvesson (1990: 376), images are co-created by the organization and its environment as a “result of projection from two directions”. By aligning organizational images to prevailing societal expectations, organizations have an important avenue for producing the right impressions among constituents in the environment and thus attaining legitimacy (Richardson & Dowling, 1986).

NPM literature has devoted much attention to the empirical examination of changes in structure among public sector organizations such as the emergence of managerialism. In the same vein, neoinstitutional literature has mostly focused on changes in organizational structure when attempting to explain homogenization among fields. However, the pursuit of legitimacy is an aspect that links organizational image with organizational structure. Despite this, image is a concept that has been left rather untouched by NPM and neoinstitutional scholars.

Against this background, the purpose of the present thesis is to explore whether and how the organizational images of hospitals have accompanied the change in organizational structure from professionalism to managerialism. In other words, the thesis’ purpose is to investigate whether and how hospitals’ images covariate positively with the shift in structure mentioned above. According to the literature, the change in structure related to the logics of work control has been in motion since the 1980s and it is driven by the hospitals’ desire to align with societal expectations of increased efficiency in public sectors. Researchers therefore see such a shift in organizational structure as being inherently concerned with the attainment of legitimacy. Because scholars state that organizational images are also focused on the achievement of legitimacy, this thesis posits that images will attempt to appeal to the same societal expectations of efficiency as the hospitals’ change in organizational structure. Therefore, the present thesis postulates that the organizational images of hospitals should accompany the change in structure related to the two logics of work control. The research question is thus, to what extent is professionalism and managerialism present in contemporary hospitals’ organizational images? Based on the literature, managerialism should be the most prominent logic of work control in the structure of hospitals nowadays. As a consequence, this thesis posits that managerialism should be the most prominent logic of work control in the images of hospitals nowadays.
In order to address the purpose and research question, an organizational discourse analysis has been conducted on the website texts of a Swedish hospital sample. The data was gathered from these digital sources since both webpages (Pollach, 2005; Sullivan, 1999) and texts (Ainsworth & Hardy, 2004; Alvesson & Kärreman, 2000a) are seen as powerful channels for image-building in the literature. However, this thesis has limited its scope to studying the texts displayed on the hospitals’ websites in 2005 and 2013 even though the change in structure related to logics of work control has been in progress since the 1980s.

The results of the study indicate that a mix of professionalism and managerialism is present in the organizational images of the hospitals when analyzing the whole sample. Nevertheless, a slight growth in the latter logic of work control can be noted between 2005 and 2013. By looking at each of the individual hospitals, the impression of a mix is however reinforced once again. In 2005, private entities show more aspects connected to both logics of work control in their images than their public counterparts. The public entities have however caught up with the private hospitals in 2013 when it comes to both professionalism and managerialism. Nonetheless, the two logics of work control remain blended among the individual hospitals in 2013. Based on these findings, it seems as if managerialism does not hold a hegemonic position in the hospitals’ organizational images. Therefore, the study also makes it clear that the images have not fully accompanied the change in structure related to the logics of work control.

These findings stand in contrast with the thesis’ postulated idea that managerialism should be the most prominent logic of work control in the images of the analyzed hospitals. While NPM literature can be rather decisive in stating that managerialism has gradually become a new paradigm for public sectors in Western countries, the present thesis has shown that this development is more nuanced when it comes to organizational images. The findings are discussed in the light of societal expectations that perhaps demand both logics of work control to be present in images. In addition, it is speculated whether an increase in professionalism could actually be related to a growth in managerialism instead.

The present thesis is arranged in the following manner. To begin with, a conceptual framework outlines the theoretical line of argumentation. After this, a description of the Swedish healthcare and hospital field is provided as an empirical setting. In what follows, the thesis’ methods are described. Subsequently, the results of the conducted analysis are presented. The thesis ends by discussing the findings, putting forward contributions, accounting for certain limitations and suggesting avenues for further research in the area.

2. Conceptual framework
This thesis’ purpose is to explore whether and how hospitals’ organizational images have accompanied the change in organizational structure from professionalism to
managerialism. In order to investigate this, a number of concepts from the literature will be used to form a theoretical line of argumentation. In the literature, professionalism is seen as the historically dominant logic of work control in hospitals. Due to the introduction of private actors and business-inspired ideas into public sectors, scholars have argued that professionalism in hospitals has gradually been replaced by the work logic of managerialism during the last three decades. According to the literature, hospitals have conducted this change in organizational structure as a means of appealing to prevailing norms of and beliefs about increased efficiency in public sectors. Many researchers regard such a change in structure as being inherently focused on the achievement of legitimacy among constituents in the environment. Seeing as the literature contends that organizational images are also concerned with the attainment of legitimacy, this thesis postulates that images will attempt to align with the same norms of and beliefs about efficiency as the hospitals’ change in organizational structure. That is, the present thesis posits that the organizational images of hospitals should covary positively with the change in structure related to the two logics of work control. From extant literature, it is understood that managerialism should be the most noticeable logic of work control in the organizational structure of hospitals today. As a consequence of this, the present thesis postulates that managerialism should be the most noticeable logic of work control in the organizational images of hospitals today. Below is a more detailed description of the theoretical argumentation.

2.1 The historical dominance of medical professions in the organizational structure of hospitals
Traditionally, hospitals’ organizational structure has been based upon the logic of work control denominated professionalism (Scott et al., 2000; Östergren & Sahlin-Andersson, 1998). Under these conditions, medical professions have been given substantial autonomy to guarantee the quality of their work without external interference (Freidson, 2001). The ability to control the assessment of its members’ work is at the core of professional authority and independence (Freidson, 1994; Pollitt, 1990). This discretionary freedom is made legitimate by the long education, extensive on-site training and command of a tacit body of knowledge among medical professions (Mintzberg, 1993). In addition, institutional structures such as professional associations, educational establishments and state licensures provide control mechanisms that also uphold the autonomy of professionals (Abbott, 1988; Freidson, 1994). Professionalism is thus a logic that mostly relies on trust since it is relatively opaque and non-transparent to outsiders (Meyer & Rowan, 1977; Mintzberg, 1993).

Levay and Waks (2009: 510) state that the “important components of tacit knowledge embedded in a particular context of lived, everyday practice” make it challenging to measure the outcomes of professional work in hospitals. Attempts to represent it numerically or with other types of information can lead to misunderstandings and more difficult working conditions (Tsoukas, 1997). Professional status in public
hospitals is maintained by keeping a certain balance between standardization and uniqueness (Levay & Waks, 2009). First, professionals must be able to measure and prove the quality of their work in order to uphold their power claims. At the same time, professionals do not want their work to be measured too easily since it may open up for control from the environment (Abbott, 1988). Second, explicit knowledge and general routines ensure an even quality in the education of new professionals which is necessary for maintaining societal recognition. However, work must also be tacit enough for professionals to make relatively independent decisions and avoid having their work controlled by outsiders (Sarfatti Larson, 1977). Professions are interested in keeping the opaqueness and non-transparency of their work in order to protect their freedom of discretion. However, professionals simultaneously have to keep a certain degree of openness if they are to maintain societal recognition. The maintenance of the professional status in hospitals is therefore a balancing act where both standardization and uniqueness are equally important facets.

The tacit character of the professionals’ knowledge delimits the organizational forms that are able to control the work in hospitals. However, the significant autonomy that is given to professionals does not entail that control is entirely absent. Along this line of thought, Mintzberg (1993) states that the professional bureaucracy is the main form for organizing work in hospitals. This arrangement is characterized by the dominance of medical professionals with long education and extensive training in their specialization (Scott et al., 2000). Freidson (1970: 77) exemplifies this notion by writing that “the most important single element in the social structure of medical care is the medical profession itself”. Physicians are thus said to play a unique role in establishing coordination mechanisms in the professional bureaucracy (Fennell & Alexander, 1993; Scott & Backman, 1990). Besides the medical professions, professional associations exert control over workforce sizes, training programs, licenses and titles (Scott et al., 2000). Over time, the development of dominant beliefs and values within the medical professions also provide means of normative control (Knudsen & Vinge, 2003). Transparency efforts that attempt to rupture the professional bureaucracy and make professional practice more accessible to external control can therefore be expected to face resistance (Blomgren & Waks, 2011; Carvalho, 2012; Levay & Waks, 2009).

2.2 The gradual takeover of managerialism in hospitals’ organizational structure

The self-governance in hospitals related to the logic of professionalism has been challenged during the last three decades by the introduction of market-influenced ideas and private actors into public sectors, a general trend known as NPM in the literature (Hood, 1991, 1995; Scott et al., 2000). As a consequence of these changes, a new business-inspired logic of work control known as managerialism has gradually come to dominate the organizational structure of hospitals (Evetts, 2003; Pollitt, 1998; Scott et al., 2000).
Managerialism began to surface during the latter part of the 19th century after the co-founder of the Yale Lock Manufacturing Company, Henry R. Towne, delivered a speech in 1886 to the American Society of Mechanical Engineers. There, he argued that management should be regarded as a set of practices that could be studied and improved. According to Towne, such practices should be rooted in economics and they were therefore concerned with achieving maximum efficiency out of scarce resources (Kiechel, 2012).

Three perhaps more famous names in the history of managerialism are Frederick Taylor, Henri Fayol and Peter Drucker. In 1911, Frederick Taylor published his “Principles of Scientific Management” in which he emphasized the necessity of regarding industrial work as something quantifiable and measurable (Taylor, 2006). Five years later, Henri Fayol outlined a list of propositions with which he believed that companies were to be run. Among others, these included emphasizing budgeting, separating functions and controlling work hierarchically (Fayol, 1949). Influenced by the works of Taylor and Fayol, Peter Drucker (1964) published “Managing for Results” several decades later. In this book, he argued that businesses are created to produce results and managers have the ultimate responsibility in this pursuit.

In more descriptive works by Pollitt (1990, 1993, 1998), five central tenets of the managerialism logic are outlined. First, managerialism asserts that the main route to progress in society is the achievement of economically defined productivity. Second, the logic asserts that the road to such productivity increases will come from the application of ever-more advanced technologies. Included in these are both cutting-edge hardware for producing material goods and new arrangements for the control of work. Third, it is said that the implementation of these aforementioned technologies can only be achieved if the labor force is educated into the ideal of increased productivity. Fourth, management is a distinct function that plays a central role in planning, introducing and measuring the productivity improvements. The success of these efforts is said to mostly depend on the skills possessed by the managers. Finally, the logic of managerialism states that managers must be given the authority to make independent decisions if they are to perform their role successfully. Managerialism is thus to be seen as a set of beliefs, values and ideas about how work should be organized for the maximization of societal benefits (Pollitt 1990, 1993, 1998).

As has been mentioned earlier, NPM-related changes have gradually replaced the logic of professionalism for one of managerialism in the work control of hospitals (Hood, 1991, 1995; Scott et al., 2000). In the literature, NPM arose as an umbrella label for public sector reforms that started in Anglo-Saxon countries during the 1980s and later spread to several parts of the Western world (Sahlin-Andersson, 2001). Olson et al. (1998) write that the reforms were triggered by citizens’ concerns about the perceived inefficiency of government spending in public sectors. By accepting private actors and
introducing business-influenced ideas, politicians have argued that NPM has the capacity to revitalize dormant public sectors (Hood, 1995).

In line with NPM-reforms, managerialism has been imported into hospitals as a means of maximizing performance, profit and service (Pollitt, 1990). As a consequence, much attention is given to the enhancement of efficiency through control mechanisms such as rules, incentives, objectives and goals (Deetz, 1992; Krantz & Gilmore, 1990). Furthermore, clear accounting procedures are seen as important ways of presenting and legitimating the outcomes of medical professions’ work (Pollitt, 1993). Krantz and Gilmore (1990) state that the implementation of such analytical tools can almost be seen as ends in themselves since they establish and maintain legitimacy in a society concerned with efficiency. This gradual replacement of professionalism in hospitals has meant that medical professions are increasingly required to account for the quality of their work to non-professional managers (Blomgren & Waks, 2011; Calnan & Gabe, 2001; Power, 1997). Such inspections and evaluations from organizational outsiders are aspects of societal control which “violate the assumption that everyone is acting with competence and in good faith” (Meyer & Rowan, 1977: 359).

The table that follows (Table 1) provides a summary of the two logics of work control that have dominated the organizational structure of hospitals according to the literature.

<table>
<thead>
<tr>
<th>LOGIC OF WORK CONTROL</th>
<th>PROFESSIONALISM</th>
<th>MANAGERIALISM</th>
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<tr>
<td>CENTRAL ACTORS</td>
<td>Medical professions</td>
<td>Managers</td>
</tr>
<tr>
<td>FORMS OF CONTROL</td>
<td>Self-governance</td>
<td>Managerial governance</td>
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<td></td>
<td>Professional norms and values</td>
<td>Incentives</td>
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<td>Professional associations</td>
<td>Functional separation</td>
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<td></td>
<td>Educational establishments</td>
<td>Productivity measures</td>
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<td>State licensures</td>
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<td>LEGITIMACY PROVIDERS</td>
<td>Long education</td>
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<td></td>
<td>On-site training</td>
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<td>Tacit body of knowledge</td>
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<td>MAIN PURSUIT</td>
<td>Quality</td>
<td>Efficiency</td>
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Table 1. Professionalism and managerialism in hospitals summarized

2.3 Adapting organizational structures to societal expectations
The shift from professionalism to managerialism as the new dominating logic of work control in medical professions has affected most hospitals in the Western world (Christensen & Lægreid, 2001). Neoinstitutional theorists would explicate such a change in structure by arguing that organizations in a delimited field cannot be too different from
their competitors due to socially dictated norms of and beliefs about appropriate organizational behavior (DiMaggio & Powell, 1983). Research within the neoinstitutionalist vein has concluded that organizations can achieve legitimacy by designing a structure that aligns to such norms and beliefs (Meyer & Rowan, 1977; Oliver, 1991).

At the end of the 1970s, much research was concentrated around organizations’ competition for scarce resources (Hannan & Freeman, 1977; Pfeffer & Salancik, 1978). Around the same time, early neoinstitutional scholars instead started emphasizing social constructivist explanations for the behavior of organizations. In this line of thinking, Meyer and Rowan (1977) state that organizational choice is constrained by a number of pressures relating to societal expectations of appropriate organizational behavior. These pressures come from constituents in the institutional environment such as governmental agencies, laws, courts, professions, interest groups and the public opinion (DiMaggio & Powell, 1983). Institutionalization then alludes to the processes by which the constituents’ prevailing societal expectations of appropriate organizational behavior gradually gain a taken-for-granted status in the form of norms and beliefs (Meyer & Rowan, 1977).

In this way, Zucker (1987) argues that organizational structures can be institutionalized and become reproduced almost blindly in order to align to the pressures deriving from the institutional environment. Over time, conforming to such institutionalized structures becomes an important aspect for continued survival according to Meyer and Rowan (1977). Oliver (1991: 169) writes that when institutionalized structures become widely diffused and supported, organizations are predicted to adhere to them “because their social validity is largely unquestioned”. In line with neoinstitutional arguments, Carvalho (2012) argues that the hospitals’ shift in logics of work control is a matter of adapting to institutionalized organizational structures.

DiMaggio and Powell (1983) contend that pressures related to societal expectations for what constitutes appropriate organizational behavior are at their strongest in delimited organizational fields such as the one in which hospitals operate. The concept of organizational field is defined as a group of interdependent populations of organizations participating in the same cultural and social sub-system (DiMaggio & Powell, 1983; Scott & Meyer, 1983). By appealing to social norms of and beliefs about appropriate organizational behavior, organizations establish and maintain legitimacy in the eyes of the field’s environmental constituents (DiMaggio & Powell, 1983). The introduction and subsequent wide spread of managerialism in hospitals is therefore seen as way of achieving legitimacy by appealing to contemporary societal demands for more efficient public sectors (Carvalho, 2012).

2.4 Adapting organizational images to societal expectations
In addition to the neoinstitutionalist emphasis on structure, several researchers in the management, marketing and corporate communication literatures have also stressed the
centrality of organizational image in achieving legitimacy (Gioia et al., 2000; Hatch & Schultz, 2002; King & Whetten, 2008; Van Riel & Balmer, 1997; Whetten & Mackey, 2002).

According to Alvesson (1990), image has risen as an important concept due to wide shifts in the economy. More specifically, Grönroos (1984) sees the decline of industrialism and the subsequent expansion of the service sector as one reason for the contemporary salience of organizational image. This new economic climate has come to be dominated by the provision of intangible products while the traditional manufacturing of goods has become less important (Parrinello, 2004). Under such circumstances, consumers find it more difficult to anchor their judgments in material reality and instead increasingly rely on organizational images to guide their choices (Alvesson, 2011). Another reason for the emergence of image is the larger distance between people and institutions in their lives (Alvesson, 1990). Today’s global consumption patterns have replaced local communities and businesses that earlier dominated most persons’ everyday life (Hertz, 2003). Already in 1961, Boorstin stated that consumers only have a vague notion of what is happening within the corporations in their lives and therefore come to rely on organizational images instead (Boorstin, 1961). A final reason for the rise of image is that contemporary companies must do more than obey laws and deliver profits (Alvesson, 1990). Different interest groups also place demands concerning environmental issues, employment conditions and equal treatment of minorities (McWilliams & Siegel, 2001). By aligning organizational images to prevailing societal expectations, organizations have an important avenue for producing the right impressions among constituents in the environment and thus attaining legitimacy (Richardson & Dowling, 1986).

Despite researchers’ agreement on the importance of image, the concept has still been the subject of many different definitions in extant literature. Grunig (1993) explains these differences by making a rough division between internal and external approaches to organizational image. In the former, image is regarded as a message created by the communicator and consumed by groups in the environment. In the latter approach, organizational image is instead seen as something constructed by the perceptions of outsiders.

Alvesson (1990) presents a more holistic conceptualization of organizational image by incorporating both the internal and external approaches into one definition. In his line of thought, image is the outcome of both the organization’s communication of a fabricated picture and sensemaking by an individual or a group. This process of co-creation between the organization and its environment thus implies that organizational image is the “result of projection from two directions” (Alvesson, 1990: 376). On the internal side, the process includes organizational elites deliberately attempting to influence public impressions but also everyday interactions between the organization and outsiders (Barich & Kotler, 1991). On the external side of the process, particular actors
with vested interests are involved in the formation of an image when they affect the perceptions of an individual or a group (Dowling, 1993). Organizational images are ambiguous and thus situate themselves somewhere “between the imagination and the senses, between expectation and reality” (Boorstin, 1961: 163). If the organization is to benefit, outsiders should therefore not perceive its image as something untrue or falsifiable (Alvesson, 1990; Grönroos, 2007).

Against this background, it becomes clear that organizational images are inherently connected with the attainment of legitimacy. In the case of contemporary hospitals, researchers have stated that legitimacy is achieved by aligning to societal expectations of increased efficiency in public sector organizations. Therefore, this thesis posits that images will accompany the shift in organizational structure from professionalism to managerialism since both image and structure are concerned with conforming to the same societal expectations for the achievement of legitimacy. As a consequence of this, the present thesis furthermore postulates that managerialism should nowadays be the most prominent logic of work control in the organizational images of hospitals.

2.5 Summarizing the theoretical line of argumentation
The following line of argumentation has been presented in this theoretical section. In the literature, professionalism is described as the historically dominant logic of work control in hospitals. However, scholars write that this dominance has been threatened by the introduction of private actors and business-inspired ideas into public sectors after NPM reforms that have swept through most Western countries during the last three decades. All of this has led researchers to conclude that professionalism has gradually come to be replaced by the logic of managerialism as the new dominant logic of work control in hospitals. According to the literature, this shift in organizational structure has been conducted in order to conform to contemporary norms of and beliefs about increased efficiency in public sectors. Therefore, scholars regard such a change in structure as being inherently focused on the attainment of legitimacy among constituents in the institutional environment. Since researchers have stated that organizational images are also central for the achievement of legitimacy, this thesis postulates that images will accompany the shift in organizational structure from professionalism to managerialism. The present thesis posits that the reason for this positive covariation is that both image and structure attempt to appeal to the same norms of and beliefs about increased efficiency in public sectors. From the literature, it can be derived that managerialism should be the most prominent logic of work control in the structure of hospitals nowadays. As a consequence, this thesis postulates that managerialism should be the most prominent logic of work control in the images of hospitals nowadays. The model below (Model 1) summarizes the theoretical line of argumentation in a graphic manner.
3. Empirical setting
As has been mentioned before, this thesis asks to what extent professionalism and managerialism are present in contemporary hospitals’ organizational images. The research question will be answered by analyzing a sample of the Swedish hospital population in the years 2005 and 2013. In order to describe the characteristics of the empirical field in focus, this section commences by providing an account of NPM-related changes and current conditions in Sweden’s healthcare sector. The second part of the empirical setting follows a similar structure but it is centered on Swedish hospitals specifically since these entities constitute the units of study in this thesis. As is made apparent in these two parts, research shows that Sweden’s welfare state had traditionally trumpeted equity and universal access to healthcare. With the advent of NPM reforms, scholars have however argued that the notion of efficiency has increasingly gained ground in the country’s public sector. Just as in many other parts of the Western world, the literature concludes that a significant transformation has taken place in Swedish healthcare and hospitals throughout the last three decades.

3.1 Swedish healthcare: From the middle of the 19th century to present times
Healthcare has for a long time been one of the pillars in Sweden’s welfare society and it has traditionally emphasized the notion of equity over efficiency (Lindgren, 1995a; Lytkens & Borgquist, 1995). The second paragraph of the 1982 Swedish Healthcare Act states that the “fundamental objectives of healthcare in Sweden are good health and healthcare on equal terms for the entire population” (Government Offices of Sweden’s
Although significant changes have taken place in Sweden’s public sector during the last three decades as a consequence of demands for increased efficiency in government spending (Öhrming, 2008). Healthcare was no exception and Lindgren (1995a: 259) writes that the growing pressure in the beginning of the 1980s was “a rather rude awakening for many healthcare actors” in Sweden.

Public provision of healthcare accounted for a substantial share of the total healthcare sector already in the middle of the 19th century (Lindgren, 1995b). After the 1959 hospital reform, the public sphere maintained a near-monopoly status in the sector for more than two decades (Palier, 2006). Up until the early 1980s, the Swedish state centrally financed and managed more than 90 per cent of healthcare in the country (Alban & Christiansen, 1995). A constant flow of resources to the sector was necessary to ensure the promised universal accessibility and coverage for all citizens (Öhrming, 2008). Budgets were allocated to healthcare districts but there was no obvious link between the number of patients and the provided resources. Rather, budgets were usually formulated on the basis of preceding years’ expenditures with adjustments for inflation (Lindgren, 1995b).

However, the Swedish public sector came under scrutiny just as NPM-reforms started taking hold in many other Western countries. Sweden faced a marked slowing-down in its post-war economic growth during the 1970s and 1980s. Healthcare still accounted for approximately 9 per cent of the country’s gross domestic product in 1980 but the sector had become increasingly questioned for its perceived inefficiency (Lindgren, 1986; Lindgren & Roos, 1985). Together, this meant that financing healthcare with more taxes became a political difficulty (Norbäck & Targama, 2009). After years of discussions, NPM-inspired reforms were introduced at the end of the 1980s and the beginning of the 1990s (Siverbo, 2004). In relation to other countries, Sweden was a late adopter but NPM had become an attractive alternative since it had the capacity of improving efficiency and increasing long-term productivity in Swedish healthcare (Öhrming, 2008). Against this background, the sector became the target of a comprehensive transformation during the 1980s and 1990s where marketization was a central tenet (Bergmark, 2008; Harrison & Calltorp, 2000). Ideas and practices that had previously been reserved for private businesses were now being adopted on a wide scale throughout Swedish healthcare (Siverbo, 2004). Previous central plans for healthcare provision were abandoned by the state and instead counties became responsible for making up the details regarding the distribution of resources (Anell & Svarvar, 1995). Other common features of the Swedish reforms included profit centers, purchaser-provider splits, budgets based on population characteristics and some privatizations (Lyttkens & Borgquist, 1995).

The role of the Swedish government in today’s healthcare is to set general frameworks for healthcare provision and to perform surveillance of the sector (Alban & Christensen, 1995; Lindgren, 1995b). Health services are financed through taxes and state subsidies but planning and delivery is left to the political boards in Sweden’s 21 counties.
4 of these 21 counties are labeled regions but they basically have the same responsibilities (Anell et al., 2012; Swedish Association of Local Authorities and Regions’ website, 2013a). The Swedish health law is nowadays formulated so as to give the counties a high degree of freedom and autonomy when it comes to the structure of their healthcare provision (Government Offices of Sweden’s website, 2013). Contemporary healthcare in Sweden should therefore not be seen as a centralized national service, it is rather a “system which allows many different varieties” (Lindgren, 1995b: 245). Swedish healthcare is presently divided into three levels: regional care, county care and primary care. There are currently seven regional hospitals, 70 county hospitals and more than 1000 health centers in the country (Swedish Association of Local Authorities and Regions’ website, 2013b).

The center-right government in 1991-1994 and 2006-present has supported free healthcare choice and privatization of services in the area (Anell et al., 2012). Since 2003, Swedish citizens are entitled to seek public or private healthcare anywhere in the country on the same conditions as in the county that they belong to (Vrangbæk et al., 2007). All actors that fulfill the counties’ requirements are presently allowed to provide healthcare and at the same time receive reimbursement from public funds for the patients that they treat. In other words, it is said that the money follows the patients’ choice. The goal with these initiatives is to increase quality and decrease waiting times by introducing aspects of competition into the hospital sector (Government Offices of Sweden’s website, 2013). However, studies in Sweden, Norway and Denmark show that patients have not used this freedom of choice much (Vrangbæk et al., 2007). What is more, county-funded healthcare bought from private providers corresponded to less than 10 per cent of the counties’ total costs for healthcare in 2005. The share of private healthcare paid entirely by the patients themselves constitutes an even smaller fraction of the healthcare sector (Swedish Insurance Federation’s website, 2013).

3.2 Sweden’s hospital sector: Exponential changes during the last sixty years
The share of healthcare given through hospitals in Sweden has grown markedly since the early 1950s. At this time, most doctors worked outside of hospitals and still maintained a custom of paying home-visits to patients. What followed after this decade was an enormous expansion of the hospital sector that continued well into the 1970s (Lindgren, 1995b).

The Swedish Association of Local Authorities and Regions defines hospitals as those entities that provide inpatient slots for specialized somatic care. As of October 2012, 77 such entities were operating in Sweden. The majority of hospitals are situated in the southern and mid-parts of the country and in or around the metropolitan areas of Stockholm, Göteborg and Skåne. Out of the hospital population, seven are categorized as regional hospitals (Swedish Association of Local Authorities and Regions’ website, 2013b). They are public entities affiliated with medical schools and research and provide citizens with advanced treatment facilities in 40-50 specialties. Regional hospitals often
carry the responsibility of serving several counties or even the whole country in some highly specialized medical areas such as bone-marrow, liver or heart transplants. Their financing is thus contingent on cooperative agreements among the involved parties (Lindgren, 1995b). In addition, 70 county hospitals are geographically spread throughout the country (Swedish Association of Local Authorities and Regions’s website, 2013b). This group is composed of public hospitals with fewer specialties and less inter-county responsibilities than their regional counterparts (Lindgren, 1995b). The hospitals also differ in size when measured on the number of beds being provided for somatic care. The regional public hospitals Sahlgrenska University Hospital in Göteborg, Karolinska University Hospital in Stockholm and Akademiska University Hospital in Uppsala are the three biggest entities with 1529, 1410 and 859 beds respectively (Swedish Association of Local Authorities and Regions’ website, 2013b).

Among the 77 hospitals, 6 are privately owned. The private hospitals are located in Stockholm county, Uppsala county and the Västra Götaland region (Anell et al., 2012). Two of these hospitals are owned by Capio which is a Swedish healthcare group founded in 1994 and later acquired by three international private equity funds. During the last ten years, the group has rapidly expanded its business abroad and currently operates in Sweden, Norway, France, Germany and the UK. The Capio group is composed of about 100 care units with some 11,000 employees and treats more than 3 millions patients every year. Its annual sales amount to approximately 12 billion Swedish crowns (SEK) (Capio’s website, 2013). Furthermore, one private hospital is owned by Aleris, another Swedish healthcare group established in 2005 and presently managed by a Stockholm-based investment company. Aleris is nowadays present in Sweden, Norway and Denmark. The group has about 7000 employees and its yearly sales amount to approximately 7 billion SEK (Aleris’ website, 2013). Finally, the three remaining private hospitals are owned by the non-profit organizations Carlanderska (Carlanderska Hospital’s website, 2013), Ersta diakoni (Ersta Hospital’s website 2013) and Sophiahemmet respectively (Sophiahemmet Hospital’s website, 2013).

Private actors were allowed to enter the Swedish hospital field after the country’s introduction of NPM-reforms at the end of the 1980s and beginning of the 1990s (Siverbo, 2004). Along with these changes, business-influenced ideas have gradually come to replace the historically dominant logic of professionalism in the organizational structure of Sweden’s hospitals. Therefore, a new logic of work control labeled as managerialism has risen to prominence in the structure of the country’s hospitals (Blomgren & Waks, 2011). By analyzing a sample of Swedish hospitals, this thesis investigates whether and how their organizational images have accompanied the change in structure from professionalism to managerialism.

4. Methods
In the following section, the thesis’ methods are explained. A qualitative study consisting
of an organizational discourse analysis has been conducted in order to analyze the extent of professionalism and managerialism present in the organizational images of the hospital sample. Organizational discourse theorists have stated that language is a central part of image-building efforts since it has the capacity of constructing social reality. Therefore, the present thesis has decided to study the organizational images as seen in the webpage texts of the chosen hospitals. Through the study of textual discourses presented on websites, this thesis attempts to analyze whether and how hospitals have adapted their images to prevailing social norms of and beliefs about increased efficiency in public sectors.

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*Model 2. Expectations, structure and image: Historical development and focus of the present study*

The model above (Model 2) describes the relation between the three levels of change from professionalism to managerialism as posited by this thesis. In the literature, it is argued that the organizational structure of hospitals has been aligned with prevailing societal expectations. Based on this, the present thesis postulates that organizational images will show a positive covariance with organizational structure since both of these concepts attempt to appeal to the same societal expectations. As can be seen in the model, the change in expectations and structure has been in progress since the 1980s but this thesis has limited its scope to studying the accompanying images of the selected hospitals in 2005 and 2013.

4.1 Exploring organizational images through qualitative studies

Schilling (2009) states that qualitative studies can help to identify a phenomenon more in depth. Furthermore, it is argued that such studies provide clues as to how changes have occurred (Cassell & Symon, 1994). Insights like these are not provided by quantitative studies that analyze whole populations and derive statistical generalizations from them (Leedy & Ormrod, 2001; Miles & Huberman, 1994; Morgan & Smircich, 1980). Against this, a qualitative approach has been deemed to be appropriate given that the present thesis is of an explorative character and analyzes an untouched aspect in the literature.

Interpretive aspects are integral parts of qualitative studies but the norm of reproducibility nevertheless remains important (Denzin & Lincoln, 1998; Morse, 1994).
There has therefore been a long tradition among qualitative researchers of documenting the process by which interpretations are made (Glaser & Strauss, 1967; Guba, 1981). By showing the process of interpretation, another researcher can follow the line of thought and make a personal analysis of the material (Strauss & Corbin, 1998). This aspect is important since authors can become affected by their own discourses during the study at hand. That is, previous knowledge and understanding might guide what is searched for but also what is seen (Auerbach & Silverstein, 2003). The present thesis acknowledges these warnings and therefore presents the interpretation process further down in the methods section. In addition, an appendix with the full extent of the analyzed material is provided at the end of the thesis.

4.2 Explaining social reality through organizational discourse analyses
Qualitative research in the fields of marketing, sociology and communications theory (Deetz, 1992; Dyer, 1982; Silverman, 1993) has demonstrated the significance of analyzing language in social sciences. In organizational studies, this insight has gradually made language the most used parameter for empirical investigation in the area (Alvesson & Kärreman, 2000a). Language is an interpretable phenomenon that contributes to the construction of social reality and thus becomes an integral part of image building efforts (Ainsworth & Hardy, 2004). Since this thesis explores the extent of professionalism and managerialism in the images displayed on the websites of a hospital sample, an organizational discourse analysis has been conducted to study the language used in the written texts on these webpages.

The term organizational discourse refers to “the structured collections of texts embodied in the practices of talking and writing… that bring organizationally related objects into being” (Grant et al., 2004: 3). Discourses such as these are argued to constitute the social world since they give meaning to actions and identities (Phillips & Hardy, 2002). Organizational discourse analysts therefore engage in systematic studies of texts in order to explain the relationship between organizational discourses and social reality (Fairclough, 1992; Grant & Hardy, 2004; Phillips & Hardy, 2002).

However, organizational discourse analysis is approached in at least two ways in the extant literature. On the one hand, the term can refer to the study of talk and written text in its social action contexts (Potter & Wetherell, 1987). This approach focuses on the “talked and textual” (Alvesson & Kärreman, 2000b: 1126) nature of local interaction in organizations and disregards higher levels of general content (Boje, 1991). On the other hand, organizational discourse analysis can also imply the study of language as a constructor and maintainer of social reality (Chia, 2000; Putnam & Fairhurst, 2001). According to this approach, organizational discourse produces a certain version of reality and excludes others that are not seen as legitimate accounts of knowledge (Alvesson, 2004). Proponents of this latter approach claim that organizational discourse has been misunderstood by many as “discourse about organizations or about what goes on within organizations” (Chia, 2000: 514) when it should rather be seen as a constitutor of societal
ideas in a certain period of time (Alvesson & Kärreman, 2000b). The present thesis adheres to this social constructivist perspective of organizational discourse and has used it to analyze the webpage texts of the chosen hospitals. Given that the legitimacy of organizations is based on conforming to socially constructed norms and beliefs, it is insisted that an organizational discourse analysis cannot be conducted without paying attention to wider societal settings such as NPM in this case.

4.3 The present study and its data
According to Carvalho (2012), private actors have been drivers in the change from professionalism to managerialism in hospital sectors. The present study has therefore chosen to investigate the websites of all of the 6 private hospitals and 12 public hospitals in Sweden’s Västra Götaland region, Uppsala county and Stockholm county. In line with the Swedish Association of Local Authorities and Regions (Swedish Association of Local Authorities and Regions’ website, 2013b), this thesis has delimited the term “hospital” to include those entities that provide specialized somatic care with inpatient slots.

The hospital population sample was made since the totality of Sweden’s 6 private hospitals are located in the aforementioned areas and this thesis posits that the influx of business-influenced ideas could be stronger there than in other parts of the country. Because of this, the change in structure from professionalism to managerialism and the accompanying change in organizational image might be more noticeable within the chosen sample than outside of it. Since the chosen region and counties are densely populated areas of Sweden with many inhabitants, this thesis also contends that patients might not have a personal connection to their local hospital and images could therefore gain a more prominent role. In line with Boorstin’s (1961) thoughts, a vague notion among citizens about what is happening within hospitals might mean that these entities increasingly come to rely on organizational images when attempting to gain legitimacy. The factors mentioned above could together have an influence on the image-building efforts of hospitals and the chosen sample has therefore been deemed as appropriate for answering the thesis’ research question.

Due to the fast-paced nature of the Internet, Pollach (2005) states that future research should conduct longitudinal studies in order to capture the evolutionary nature of websites. As a response to this call, the present thesis analyzes the hospitals’ webpages in the second half of 2005 and compares them with the webpages of the same hospitals in the first half of 2013. A longitudinal study of this sort can observe “important changes that organizations are undergoing” (Van de Ven & Huber, 1990: 218-219). Therefore, this thesis contends that the analysis of webpages over time is a proper method since it has the potential of discovering possible differences when comparing the two studied years.

The starting point for the longitudinal study was set to the second half of 2005 because that is when Elisabeth Hospital in Uppsala county was privatized. It was thus during this period that the hospital population in the sampled region and counties was
established as it is today. To get as large time spread as possible, the first half of 2013 was used as an ending point for the study.

Internet Archive: Wayback Machine (Internet Archive: Wayback Machine’s website, 2013) proved to be a valuable site for the gathering of historical webpage texts. However, the website of one public hospital in the sample, Södertälje hospital, could not be found for 2005 on Internet Archive: Wayback Machine. A trip to the Royal Library in Stockholm was subsequently made in order to use its Kulturvar website over old webpages but this did not render any new information. Therefore, Södertälje hospital had to be left out of the study. All together, the longitudinal study comprises the totality of the 6 private hospitals and 12 of the 13 public hospitals in the Västra Götaland region, Uppsala county and Stockholm county.

4.4 Analyzing organizational images through webpages
Webpages are often addressed to a set of important publics (Esrock & Leichty, 2000). In addition, websites are powerful channels for image-building (Pollach, 2005; Sullivan, 1999). Based on this, the present thesis contends that webpages are suitable units of analysis when attempting to study the organizational images of the sampled hospitals.

However, this thesis acknowledges that one must tread with certain caution when analyzing webpages. Many hospital websites might be developed with standardized templates by media consultants and these webpages might not differ much from each other in this case. Nevertheless, Tyllström (Forthcoming) argues that a consultants’ main offering is legitimacy and this thesis therefore posits that their work on the websites of hospitals is likely to reflect prevailing societal expectations.

Research carried out by the media consultancy Nielsen Norman Group has shown that startpages and the sections labeled “About Us” are the most seen by Internet visitors (Nielsen Norman Group’s website, 2013). The texts in the present study have therefore been extracted from startpages and “About Us” pages since it could be argued that these two sections constitute the webpage parts with the most potential for image-building.

4.5 An iterative coding process for the analysis of professionalism and managerialism in organizational images
As mentioned earlier, the extent of professionalism and managerialism in the images of the sampled hospitals has been studied through an organizational discourse analysis. The first step in such a procedure is to categorize the chosen webpage texts with the help of different codes. The codes were developed in an iterative manner by going back and forth between the website texts and the theoretical concepts. Some codes were not directly related to theory but they were nevertheless created since they reflected recurrent patterns in the webpage texts. The initial open coding thus yielded a total of 120 codes. However, continued iteration between the codes, texts and theory displayed similarities among many of the codes. Through an axial coding process (Corbin & Strauss, 1990), the codes were constantly compared and related to each other until they could be grouped into different categories. The procedure eventually reduced the total number of codes to 62.
Taking inspiration from Corley and Gioia’s (2004) coding approach, the codes were then divided into 1st order codes, 2nd order concepts, 3rd order themes and aggregate dimensions. The 62 1st order codes reflect detailed aspects found in the texts and are thus the most numerous. The ten 2nd order concepts group related 1st order codes into fewer but wider categories. The 2nd order concepts were subsequently divided into four higher groups called 3rd order themes. Finally, the 3rd order themes form the two aggregate dimensions. The coding approach thus ranged from the numerous and detailed 1st order codes on the one end to the fewer and more general aggregate dimensions on the other end. What follows is a more detailed explanation of 2nd order concepts, 3rd order themes and aggregate dimensions.

2nd order concepts include “Justice”, “Welcomeness”, “Pleasantness”, “Competence”, “Accountability”, “Responsibility”, “Importance”, “Quality”, “Best” and “Effectiveness”. Together, these ten 2nd order concepts grouped a total of 62 1st order codes. Below is a selection of text quotations taken from the hospitals’ websites.

1. 2nd order concept: Justice

1st order code: Empathy
Example: “…attention and patient care is our primary focus” (Sahlgrenska University Hospital’s website, 2013).

1st order code: Equity
Example: “Give healthcare on equal terms…” (Danderyd Hospital’s website, 2013).

2. 2nd order concept: Welcomeness

1st order code: Welcomeness
Example: “Welcome to Capio S:t Göran’s Hospital” (Capio St. Göran Hospital’s website, 2013).

1st order code: Accessibility
Example: “… the emergency hospital in the center of the city” (Capio St. Göran Hospital’s website, 2013).

3. 2nd order concept: Pleasantness

1st order code: Pleasantness
Example: “… in beautiful premises…” (Aleris Elisabeth Hospital’s website, 2013).
1st order code: Comfort
Example: “The rooms are bright and homely. The pleasant beds are easy to adjust for a comfortable position. Each room has radio, TV and a private telephone, and those who want can connect their computers” (Sophiahemmet Hospital’s website, 2005).

4. 2nd order concept: Competence

1st order code: Competence
Example: “… care with high competence…” (Aleris Elisabeth Hospital’s website, 2005).

1st order code: Experience
Example: “Akademiska has many roles (…) That creates (…) the experience (…) that is available here” (Akademiska University Hospital’s website, 2013).

5. 2nd order concept: Accountability

1st order code: Quantification
Example: “In 2005, approximately 98,300 admissions will be produced of which 5,300 are admissions originating from outside the county or from overseas” (Karolinska University Hospital’s website, 2005).

1st order code: Transparency
Example: “Here you as a visitor can take part of the hospital’s different policy documents from the past years at Karolinska University Hospital” (Karolinska University Hospital’s website, 2013).

6. 2nd order concept: Responsibility

1st order code: Environment
Example: “Environmental work” (Ersta Hospital’s website, 2013).

1st order code: No smoking policy
Example: Sahlgrenska University Hospital is a health-promoting and non-smoking hospital. On our hospital grounds, smoking is only allowed at designated spots” (Sahlgrenska University Hospital’s website, 2013).
7. 2nd order concept: Importance

1st order code: Health system participation
Example: “Elisabeth Hospital has agreements with Uppsala county within the Free Care Choice and the hospital is also part of the county’s waiting time information system” (Aleris Elisabeth Hospital’s website, 2005).

1st order code: National profile
Example: “Every day we meet patients from Stockholm county, Sweden and from abroad” (St. Erik Hospital’s website, 2013).

8. 2nd order concept: Quality

1st order code: Quality
Example: “Our activities are embedded in a (...) continuous work for enhanced quality in all areas” (Aleris Elisabeth Hospital’s website, 2013).

1st order code: Constant improvement
Example: “The medical quality work (...) is continuously followed up by for example reporting to national quality registries” (Aleris Elisabeth Hospital’s website, 2013).

9. 2nd order concept: Best

1st order code: Best
Example: “…provide first class healthcare that makes patients and purchasers see Carlanderska as a first choice alternative” (Carlanderska Hospital’s website, 2013).

1st order code: Ambition
Example: “The ambition of Karolinska is to be a strong, positive force in making Stockholm a world leading biomedical region” (Karolinska University Hospital’s website, 2005).

10. 2nd order concept: Effectiveness

1st order code: Effectiveness
Example: “Extensive competence and high accessibility enables effective healthcare” (Capio Lundby Hospital’s website, 2005).
1st order code: Resource efficiency
Example: “The coordination between the hospitals entails synergy effects, for example in a bigger patient base supporting R&D, supporting joint healthcare programs, better financial figures by being able to share and concentrate resources, less administrative costs and a better management structure” (Karolinska University Hospital’s website, 2005).

After this, four 3rd order themes that represent broad categories of webpage texts were created in order to group the ten 2nd order concepts. These 3rd order themes include “Equity”, “Competence, “Accountability” and “Quality Work”. Equity is used to describe norms and ideas that are typically perceived as being connected to the work of hospital professionals. Included here are morality, commitment and responsibility among others. Competence denotes aspects of work that are related to the education, training and knowledge of medical professions in hospitals. Accountability is used to denote ideas of transparency and evaluations in the work of hospital professionals but also aspects such as social responsibility. Finally, Quality Work describes how the work of medical professions is increasingly connected to matters such as efficiency, effectiveness and being at the forefront of the hospital field.

As a final step, the four 3rd order themes were grouped into two aggregate dimensions. Equity and Competence were classified into the aggregate dimension labeled “Professionalism” while Accountability and Quality Work were placed in the other dimension called “Managerialism”.

In the two tables below (Table 2 and Table 3) are all the codes, concepts, themes and dimensions pertaining to the conducted organizational discourse analysis.
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Table 2: Codes, concepts, themes and dimensions relating to the professionalism logic of work control
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<tr>
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<td>Accountability</td>
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<tr>
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<td>Importance</td>
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<td>Managerialism</td>
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<tr>
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<td>Importance</td>
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<tr>
<td>Regional role</td>
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<td>Importance</td>
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<tr>
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<td>Importance</td>
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<td>Importance</td>
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<tr>
<td>Quality</td>
<td>Importance</td>
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<td>Importance</td>
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<td>Constant improvement</td>
<td>Importance</td>
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<tr>
<td>Excellence</td>
<td>Importance</td>
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<td>Importance</td>
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<tr>
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<td>Effectiveness</td>
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<td>Effectiveness</td>
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<tr>
<td>Competitiveness</td>
<td>Effectiveness</td>
<td></td>
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</tbody>
</table>

Table 3. Codes, concepts, themes and dimensions relating to the managerialism logic of work control
During the coding process, one or many different 1$^{\text{st}}$ order codes could be used to categorize the same text. That is, a text extract could receive everything from one to 62 1$^{\text{st}}$ order codes. In addition, recurring words or sentences in a text passage were coded multiple times as a way of portraying their importance. This thesis posits that the repetition of certain words or sentences imply that their relevance is higher than others which appear fewer times. The present thesis also postulates that such a repetition of words or sentences reflects a desire by the hospitals to emphasize their alignment to certain societal expectations. After the coding was finished, the 1$^{\text{st}}$ order codes pertaining to each aggregate dimension were summed. By doing this, the present study was able to get numerical and comparable measurements for the two aggregate dimensions.

4.6 Increasing the reliability in organizational discourse analyses
An inter-rater agreement test was conducted after the coding process was finished. Such a test is done in order to assess the reliability of a coding system (Banerjee et al., 1999). A ten percent sample of the webpage texts was therefore control coded by an independent researcher. In the first step, this person was given the full coding list along with the texts from four websites. After this, a meeting was held where the independent researcher’s coded sample was compared with the present thesis’ own coding of the same sample. In some instances, disagreements between the coded samples were resolved by discussing which codes best fitted the texts in question. This last step meant that the code list was eventually returned to and certain codes were improved.

5. Results
In what follows, the results of the conducted organizational discourse analysis are presented through descriptive statistics. When looking at the whole sample of hospitals, the general impression is that a blend of professionalism and managerialism is present in the images. Nonetheless, a slight increase in the latter logic of work control can be noticed between 2005 and 2013. By analyzing each of the individual hospitals, the notion of a mix is however reinforced once again. In 2005, private entities display more aspects related to both logics of work control in their organizational images than public hospitals. The public entities have however caught up with the private hospitals in 2013 when it comes to both professionalism and managerialism. Nevertheless, the two logics of work control remain blended among the individual hospitals in 2013. Below are tables and graphs which describe the findings in greater detail.
Table 4. The totality of 1st order codes related to professionalism and managerialism in absolute terms for the whole sample of hospitals in 2005 and 2013
The table above (Table 4) depicts all of the codes found when analyzing the webpage texts of the hospital sample. From this table, it can be seen that professionalism codes such as “Competence”, “Specialist Care” and “Accessibility” score highest with 16, 14 and 11 occurrences respectively in 2005. In the case of managerialism, “Constant Improvement”, “Health System Participation” and “Quantification” are three codes which place at the top during 2005 with 12, 9 and 9 appearances respectively. When summing the number of codes relating to each of the logics of work control in 2005, professionalism has 119 codes compared with managerialism’s 112.

When 2013 is analyzed, “Specialist Care”, “Competence” and “Accessibility” are once again the codes that score highest in professionalism with 21, 20 and 13 occurrences respectively. For managerialism, it can be seen that “Business Concepts”, “Quality” and “Constant Improvement” are the three most common codes in 2013 with 25, 18 and 16 appearances each. After adding the codes for the respective logics of work control, professionalism totals 157 codes against the 181 pertaining to managerialism.

Based on this, it can be noticed that both logics of work control in the hospital sample have grown in number of codes throughout the studied years but managerialism has shown a slightly bigger increase. The 9 graphs that follow describe this change through absolute terms and percentages.

5.2 The codes pertaining to both logics of work control in absolute terms for the whole hospital sample in 2005 and 2013

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A growth in number of codes related to professionalism and managerialism during the studied years

<table>
<thead>
<tr>
<th>Year</th>
<th>Professionalism</th>
<th>Managerialism</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>119</td>
<td>112</td>
</tr>
<tr>
<td>2013</td>
<td>157</td>
<td>181</td>
</tr>
</tbody>
</table>

Graph 1. The number of codes related to professionalism and managerialism in absolute terms for the whole sample of hospitals in 2005 and 2013
With the graph above (Graph 1), it becomes easier to compare the number of codes in absolute terms for the whole sample of hospitals in 2005 and 2013. As has been mentioned before, the number of codes relating to professionalism and managerialism was 119 and 112 respectively in 2005. There is therefore a relatively even mix of codes pertaining to each of the logics of work control displayed in the organizational images of the hospitals during this year. When looking at 2013, the number of codes has increased to 157 for professionalism and 181 for managerialism respectively. One can therefore say that aspects of image related to both logics of work control have increased during the studied period and that there is still a blend of codes for the whole hospital sample in 2013. However, managerialism has come to take a more prominent position than professionalism among the sampled hospitals based on the bigger difference in number of codes for 2013.

5.3 The percentual change in codes related to professionalism and managerialism in the whole hospital sample from 2005 to 2013

Both logics of work control increase in number of codes but managerialism shows a bigger growth

<table>
<thead>
<tr>
<th>Percentual change from 2005 to 2013</th>
<th>32%</th>
<th>62%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionalism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managerialism</td>
<td></td>
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</tr>
</tbody>
</table>

Graph 2. The percentual change in number of codes related to professionalism and managerialism in the whole hospital sample from 2005 to 2013

By looking at graph 2, the percentual change in number of codes for the whole sample of hospitals between 2005 and 2013 becomes clear. Through this, it can be seen that both professionalism and managerialism have increased in the hospital sample during the analyzed timeframe. However, the latter logic of work control has grown by 62 percent throughout the studied years compared with professionalism’s 32 percent. Therefore, it can be said that positions have changed in the organizational images of the sampled hospitals and managerialism has come to take a more important role than professionalism in 2013.
5.4 The two logics of work control as proportions of the total number of codes for the whole hospital sample in 2005

A relatively even proportion of codes relating to professionalism and managerialism in 2005

![Graph 3. Professionalism and managerialism as proportions of the total number of codes in 2005 for the whole hospital sample]

The graph above (Graph 3) serves to visualize the two logics of work control as proportions of the total number of codes for the whole hospital sample in 2005. By looking at this, one can see that 52 percent of the codes are related to professionalism during this year while the other 48 percent are connected to managerialism. Both logics of work control are thus relatively evenly mixed in the hospitals’ organizational images during the first of the two studied years.

5.5 Professionalism and managerialism as proportions of the total number of codes for the whole hospital sample in 2013

Managerialism grows and takes a bigger proportion of the number of codes than professionalism in 2013

![Graph 4. Professionalism and managerialism as proportions of the total number of codes in 2013 for the whole hospital sample]
In graph 4, the two logics of work control are presented as proportions of the total number of codes for the whole hospital sample in 2013. In this year, the picture for the sample of hospitals has changed when it comes to the number of codes that are related to professionalism and managerialism. There is still a blend of logics of work control in the hospitals’ images but managerialism now occupies 54 percent of the total number of codes against professionalism’s 46 percent. Based on this, the results show that there has been a slight change in proportions among the organizational images of the whole sample and managerialism has come to take a more prominent role in 2013 than in 2005.

The table and the first four graphs in this section have described the codes found for the sampled hospitals as a whole. In order to analyze whether there has been a uniform change from professionalism to managerialism within the sample, the following five graphs depict the codes for each of the individual hospitals included in the study.

5.6 The codes pertaining to both logics of work control in absolute terms for each of the sampled hospitals in 2005

![Graph 5. The number of codes related to professionalism and managerialism in absolute terms for each of the sampled hospitals in 2005](image)
The graph above (Graph 5) serves to depict the number of codes for each of the individual hospitals in 2005. What emerges in this year is a rather mixed picture in which some hospitals show many codes related to professionalism while others display several codes connected to managerialism. In this blend, it can be noticed that private entities have many codes pertaining to both logics of work control. At the same time, some public hospitals show very few or even no codes at all for both professionalism and managerialism.

5.7 The codes related to professionalism and managerialism in absolute terms for each of the sampled hospitals in 2013

Graph 6. The number of codes related to professionalism and managerialism in absolute terms for each of the sampled hospitals in 2013

Through graph 6, the number of codes in 2013 for each of the included hospitals becomes clear. When the codes are analyzed for this year, a mix consisting of both logics of work control remains among individual hospitals within the sample. However, most of the studied hospitals have shown an increase in their total number of codes and
managerialism has also come to take a bigger proportion of the organizational image in the majority of these entities. What is more, both public and private hospitals now have a more equal amount of codes related to the two logics of work control. A blend of codes pertaining to professionalism and managerialism thus remains in 2013 but the latter logic of work control has gained more ground in most of the sampled hospitals. In addition, it can be noticed that public hospitals seem to have caught up with private entities in terms of codes related to professionalism and managerialism.

5.8 The percentual change in codes pertaining to professionalism and managerialism for each of the sampled hospitals from 2005 to 2013

Graph 7. The percentual change in number of codes related to professionalism and managerialism for each of the individual hospitals from 2005 to 2013

With graph 7, it is possible to see the percentual change in number of codes related to both logics of work control between 2005 and 2013. An analysis of this graph once again reinforces the notion of a mixed picture in the organizational images of the hospital sample. What emerges when looking at each of the sampled hospitals between 2005 and 2013 is a rather incoherent development pattern. Some of the studied entities show an
increase in codes relating to professionalism while others have instead grown in managerialism. Furthermore, some hospitals have also increased in codes pertaining to both logics of work control. Nevertheless, it can be noticed that the entities showing the biggest growth have in common that they are publicly owned.

5.9 The two logics of work control in each of the sampled hospitals as proportions of the number of total codes in 2005

Marked differences between each of the sampled hospitals in the proportions of codes held in 2005

The dashed bars represent private hospitals

Graph 8. Professionalism and managerialism in individual hospitals as proportions of the total number of codes for each of the sampled hospitals in 2005

In the graph above (Graph 8), the codes related to the two logics of work control in individual hospitals are presented as proportions of the sample’s total number of codes for 2005. Based on this graph, it can be noticed that a few hospitals hold big proportions of the total professionalism and managerialism codes respectively. The entities displaying the largest proportions are for the most part private hospitals. Therefore, it seems as if some hospitals emphasize image aspects relating to both logics of work control while other entities choose not to work much with this at all.
5.10 Professionalism and managerialism in each of the sampled hospitals as proportions of the number of total codes in 2013

The final graph (Graph 9) visualizes the codes related to professionalism and managerialism in each of the individual hospitals as proportions of the total number of codes in 2013. In this year, it can be seen that the two logics of work control are more evenly distributed among the sampled hospitals than in 2005. Therefore, it seems as if public hospitals have catched up with their private counterparts when it comes to the proportions of codes related to professionalism and managerialism.

5.11 Summarizing the results

As a summary to this section, the main findings of the study are presented in what follows. When looking at the whole hospital sample, the results display a blend of codes related to professionalism and managerialism in both 2005 and 2013. However, the number of codes has grown in absolute terms for both of the logics of work control between the studied years. Along this line, it can also be noticed that the codes pertaining to managerialism have increased more than those related to professionalism between 2005 and 2013. For the whole hospital sample, managerialism can therefore be said to constitute a bigger percentage of the total number of codes in 2013 than in 2005. When looking closer at each of the individual hospitals in the sample, the notion of a mix in
codes pertaining to both logics of work control is however reinforced once again and this is especially apparent in 2005. In this year, private entities display more aspects related to both professionalism and managerialism in their organizational images than public hospitals. At the same time, many public hospitals show few or even no codes at all relating to the two logics of work control. The picture that emerges in 2013 is one in which most public entities have caught up with the private hospitals in terms of both professionalism and managerialism. Nevertheless, it can be noticed that the blend of codes relating to the logics of work control is still present within each of the individual hospitals.

6. Discussion
The present thesis’ purpose has been to analyze whether and how organizational images covariate positively with a shift in structure from one dominating logic of work control to another. The purpose has been operationalized through the following research question: To what extent is professionalism and managerialism present in contemporary hospitals’ organizational images? This question has subsequently been explored through an organizational discourse analysis conducted on the webpage texts of a Swedish sample of hospitals. The results display a blend of codes related to the two logics of work control in 2005 and 2013. Furthermore, this mix is noticed both when looking at the whole hospital sample and each of the individual entities. At the same time, a slight change in proportions from professionalism to managerialism can be seen within the studied timeframe and it is therefore concluded that the latter logic of work control has come to take a more prominent position in 2013. In what follows, the findings are discussed together with the thesis’ contributions, limitations and suggestions for further research.

6.1 The non-hegemony of professionalism and managerialism in organizational images
Based on the conducted study, it has been noticed that there is a mix of both logics of work control in the hospitals’ images. This can be seen both when looking at codes for the whole sample of hospitals and for individual entities. Therefore, it seems as if the analyzed hospitals do not want to have an image consisting of only professionalism aspects. At the same time, it is also clear that managerialism is not dominant in the organizational images either. An important finding is thus that none of the two logics of work control are hegemonic in the hospitals’ images during 2005 and 2013.

Despite the mix in organizational images mentioned above, the results also show that the blend of images related to the two logics of work control has become more homogeneous in the hospital sample between 2005 and 2013. In the study’s first year, the individual hospitals displayed a rather uneven mix of codes relating to both professionalism and managerialism. Some private entities stood for high proportions of codes related to the respective logics of work control while other public hospitals showed very few or even no aspects of image connected to professionalism and managerialism.
On the other hand, 2013 presents a more even blend in terms of number of codes among the sampled hospitals. Most of the public entities have seen a growth in aspects of image related to both professionalism and managerialism. This development has led the public hospitals to catch up with their private counterparts in aspects of image connected to the two logics of work control. The sample can therefore be said to have become more homogeneous in 2013 than in 2005 when it comes to organizational images.

The results of this study stand in contrast with the NPM literature which can be rather conclusive in stating that managerialism has gradually become a new paradigm for public sectors and thus dominates the organizational structure of most hospitals today. With the present study, it is shown that this marked shift is not something that can be noticed in the images of the sampled hospitals at least. This thesis posited that managerialism should be the most prominent logic of work control in the organizational images of contemporary hospitals if images covariate positively with the change in organizational structure. However, it seems as if the images of the analyzed hospitals have not fully accompanied the shift in structure as described by many NPM scholars. As indicated by the study, managerialism has indeed come to take a prominent place in the organizational images of the hospital sample but a positive covariation with the change in structure would have implied that managerialism had a clearer dominance in the images.

Regardless of whether the change in organizational structure related to the two logics of work control is as pronounced as has been emphasized by some scholars, the present study has shown that professionalism still maintains a strong standing in the images of the sampled hospitals. However, it has also become evident that managerialism seems to be an important aspect to confer in the organizational images of these entities. Perhaps citizens expect hospitals to simultaneously be more efficient while at the same time retaining parts of a logic that has been historically dominant in medical work. The maintenance of certain aspects of professionalism in organizational images stands in line with Mohr and White’s (2008) earlier ideas about the stickiness and endurance of institutions.

Furthermore, it can be speculated that societal ideas about how work should be controlled in hospitals have changed and now consist of a blend of two distinct logics. As a means of appealing to such mixed expectations of proper work control, neoinstitutional theory would posit that hospitals might attempt to portray an image consisting of both professionalism and managerialism in order to gain legitimacy. This would not be surprising since Sweden has a long history of emphasizing equality in and universal access to healthcare. At the same time, the country has not been an exception to the NPM reforms that have swept through most public sectors in the Western world. Achieving a mix of both professionalism and managerialism in organizational images might therefore be what is in the best interest of Swedish hospitals if legitimacy is to be attained.

The sample of hospitals used for this study comprises private hospitals and other public entities in the metropolitan areas of Sweden. Based on the characteristics of the
sample, one could also speculate that it contains many of the drivers of change in the Swedish hospital field. If societal expectations demand aspects of both managerialism and professionalism in organizational images, the driving hospitals could reinforce this by aligning to such expectations and a snowball effect might come to be created in the rest of the field. Through this, a blend of the two logics of work control may be what becomes institutionalized and taken-for-granted in the images of contemporary Swedish hospitals.

6.2 Speculating if increased professionalism in organizational images is a sign of more managerialism

In this thesis, the codes derived from the organizational discourse analysis have been divided along the lines of the two dominant logics of work control in hospitals. However, one could speculate if the codes relating to professionalism in the images of the analyzed entities might actually be connected to managerialism instead. This argument becomes plausible when one considers the paradoxality of portraying the logic of professionalism in organizational images. One of the principal aims of professionalism is to maintain opaqueness in the work control within hospitals. Through non-transparency, professionals preserve the autonomy that is necessary to evaluate the outcome of their work without external interference. In contrast, one of the main purposes of managerialism logic in hospitals is to control work through measures that increase transparency. The self-governance in the work of medical professions is therefore threatened through managerialism and its efforts to rupture the non-transparent conditions in hospitals. Against this, the portrayal of aspects related to professionalism in organizational images becomes rather paradoxical since this logic of work control is not overly concerned with communicating the outcome of medical work. Furthermore, it could even be said that promoting transparency in the work of medical professions goes against the nature of professionalism since the logic relies on autonomy and trust. With this reasoning, the number of codes pertaining to professionalism in 2005 and 2013 might therefore be related to managerialism instead.

Through images, researchers argue that organizations attempt to gain legitimacy in the eyes of the environmental constituents. Organizational images that portray both managerialism and professionalism can thus be regarded as efforts to become legitimate by aligning to contemporary societal expectations of how hospitals should control their work. The earlier mentioned possibility of more professionalism being a sign of increased managerialism can also be explained through legitimacy mechanisms. However, this thesis argues that the latter occurrence becomes clearer by making a distinction between form and content in organizational images. Both form and content are related to the attainment of legitimacy but in different ways. By separating these two concepts, an organization can allude to different societal expectations simultaneously. The combination of two legitimacy bases becomes possible when the organizational image wraps the legitimate content of one societal expectation in the legitimate form of another.
societal expectation. In the case of hospitals, this means that they can have multifaceted images containing professionalism while at the same time portraying these aspects of professionalism in a form that reminds of managerialism. As has been mentioned earlier, organizational images are ambiguous and thus situate themselves somewhere “between the imagination and the senses, between expectation and reality” (Boorstin, 1961: 163). Being such a fluid phenomenon, image has the ability to be decoupled from other aspects of organizations. This discussion of how hospitals attempt to appeal to several legitimacy bases in their images could complement earlier literature on decoupling (Meyer & Rowan, 1977), organizational hypocrisy (Brunsson, 1989), impression management (Alvesson, 1990) and symbolic management (Fiss & Zajac, 2004).

6.3 Contributions, limitations and suggestions for further research

As most hospitals in Western countries have moved from the logic of professionalism to that of managerialism in their organizational structure, researchers have argued that a new premise for legitimacy has been established in the wake of NPM reforms. According to neoinstitutional theory, it is expected that organizations will want to follow this change in structure as a means of conforming to contemporary societal demands for increased efficiency in public sectors. Since organizational images are important channels for the achievement of legitimacy, this thesis has posited that the organizational images of hospitals will accompany the shift in structure from professionalism to managerialism. The alleged connection between organizational image and organizational structure is an aspect that has been rather neglected in extant literature. In the NPM strand, scholars have mostly focused on empirical examinations of public sector reforms and related changes in structure such as the one from professionalism to managerialism. Similarly, neoinstitutional theorists have also emphasized changes in structure in their attempts to explicate homogeneity in fields and legitimacy among organizations. Image is however an aspect that has received less focus despite its inherent connection to legitimacy. Through an exploratory study, this thesis has attempted to shed light on the posited linkage between two important concepts that have earlier only received attention as separate concepts.

Nevertheless, the present thesis has certain limitations that have to be accounted for. To commence with, this study has investigated the effects of a change in structure related to logics of work control in the organizational images of hospitals during a shorter period of time. The change in organizational structure from professionalism to managerialism is one that has been in motion for three decades but this thesis only analyzes its effect on hospitals’ images for the years 2005 and 2013. What is more, the present study has not investigated what happened during each of the years within the selected timeframe neither. Therefore, this thesis should be seen as an exploratory study of organizational images comprising a period which forms part of a longer NPM trend in Western public sectors.
Another limitation is that the professionalism and managerialism logics of work control have only been analyzed as seen in the organizational images of hospitals. NPM has brought reforms that have changed the structure of many public sector areas and its effects might therefore not only limited to healthcare. In this line of thinking, the two logics of work control might be expressed in different ways on organizational structures depending on which areas of public sectors are analyzed. In its turn, this could have other effects on organizational images than the ones shown in the present thesis. Studies in the future could therefore analyze how the change in structure from professionalism to managerialism has developed through the images of organizations in other public sector areas.

When it comes to the operationalization of the study, the decision to restrict the analysis to webpages also presents some limitations. Whereas the Internet is an important avenue for organizational images, it is not the only channel for it. Many parts of organizations contribute to image and websites only constitute one aspect of these efforts. Furthermore, organizational images are never static since they are simultaneously dependent on what is visible, communicated and perceived. Therefore, future studies analyzing multiple aspects of images at the same time might yield different findings than the present.

By using webpages for the analysis of hospitals’ organizational images, a phenomenon that is hard to grasp has been demarcated and made comparable. However, certain aspects of homepages will involuntarily have a constituting relation to the analyzed images. One such aspect that could impact organizational images is the goal behind the website in question. The image portrayed on a webpage that is constructed to create a strategically determined organizational image will probably differ from one that is only developed to be used in a functional way. Against this, further research could study the extent of work that public sector organizations devote to create a specific image on websites.

6.5 Concluding remarks
As NPM reforms emerged in the 1980s, the public sectors of most Western countries witnessed a gradual shift from professionalism to managerialism in their logics of work control. In order to achieve legitimacy under these new conditions, the structure of public sector organizations has changed and become aligned to societal expectations of increased efficiency. Since organizational images are also concerned with the attainment of legitimacy, this thesis has postulated that images will covariate positively with the shift in structure from one logic of work control to another. The inherent connection between organizational images and organizational structure is a rather untouched aspect in extant literature. Against this, the present thesis has analyzed a Swedish hospital sample in order to investigate whether and how images and structure covariate positively. The results indicate that both professionalism and managerialism have increased between 2005 and 2013 even though the latter logic of work control displays a slight larger growth.
Nonetheless, the general impression that emerges in the organizational images of the sampled hospitals is a blend of professionalism and managerialism. As shown by the results, managerialism has indeed come to take a prominent place in the analyzed hospitals’ images but a positive covariation with the shift in structure would have implied that managerialism had a clearer dominance. In contrast with much of NPM literature, this thesis’ findings indicate that the change from one dominating logic of work control to another is more nuanced when it comes to organizational images at least.

References


Appendix

Aleris Elisabeth Hospital

25/11/05

"Elisabethsjukhuset är ett mindre sjukhus med specialistläkare som ligger inrymt i en vacker sekelskiftesbyggnad centralt i Uppsala." SMALLNESS; SPECIALIST CARE; PLEASANTNESS; ACCESSIBILITY
"Verksamheten är inriktad på kirurgi, främst inom ortopedi." SPECIALIST CARE
"Genom det centrala läget är det lätt att nå Elisabethsjukhuset såväl med tåg som med flyg (30 minuter från Arlanda)." ACCESSIBILITY
"Verksamheten på Elisabethsjukhuset tillhandahåler lättillgänglig specialistvård med hög kompetens bl a genom att utveckla vårdkedjor mellan primärvård, privata specialister och andra sjukhus." ACCESSIBILITY; SPECIALIST CARE; COMPETENCE; HEALTH SYSTEM PARTICIPATION; COMPLETE HOSPITAL
"Elisabethsjukhuset har avtal med Landstinget i Uppsala län som gäller vård inom det fria valet och finns även med i landstingets väntetidsinformation." HEALTH SYSTEM PARTICIPATION; WAITING TIMES

12/2/13

"Aleris Specialistvård Elisabethsjukhuset" SPECIALIST CARE
"Här på Aleris Specialistvård Elisabethsjukhuset har vi korta väntetider till vård av ortopediska besvär." WAITING TIMES; SPECIALIST CARE
"Centralt i Uppsala, i vackra lokaler, ligger ett av Sveriges främsta sjukhus inom ortopedisk kirurgi." ACCESSIBILITY; PLEASANTNESS; NATIONAL LEADER; SPECIALIST CARE
"Här får du träffa flera av landets mest erfarna specialister som utför avancerad kirurgi inom flera ortopediska områden, men
**NATIONAL LEADER; EXPERIENCE; COMPETENCE; SPECIALIST CARE**

"Vår verksamhet genomsyras av ett starkt engagemang och ett ständigt pågående arbete för förbättrad kvalitet inom alla områden."  
**COMMITMENT; PROFESSIONALISM; CONSTANT IMPROVEMENT; QUALITY**

"Det medicinska kvalitetsarbetet är av mycket hög klass och följs upp löpande genom bland annat rapportering till nationella kvalitetsregister."  
**QUALITY; MONITORING; REPORTING; CONSTANT IMPROVEMENT**

"Du har rätt att utnyttja vårdgarantin eller fritt val från ett landsting utanför Uppsala län- hör av dig till oss så hjälper vi dig."  
**WAITING TIMES**

"Modern ledproteskirurgi"  
**MODERNITY**

"Scandinavian Center of Excellence for Arthroscopy"  
**EXCELLENCE**

**Capio Lundby Hospital**

3/11/05

"Vår affärsidé:  
På Capio Lundby Sjukhus får patienten resurseffektiv vård på rätt nivå, genom samlad kompetens, tillgänglighet och kontinuitet."  
**BUSINESS CONCEPTS; RESOURCE EFFICIENCY; COMPETENCE; ACCESSIBILITY; EFFECTIVENESS**

"ISO-certifierat:  
Målet att ISO-certifiera hela sjukhuset har nu blivit verklighet tack vare ett starkt engagemang i kvalitetsarbetet bland medarbetarna på alla nivåer."  
**QUALITY; CERTIFICATION; CONSTANT IMPROVEMENT**

"Capio Lundby Sjukhus  
Specialistsjukhuset på Hisingen."  
**SPECIALIST CARE**

"Samlad kompetens och hög tillgänglighet ger rätt vård."  
**COMPETENCE; ACCESSIBILITY; EFFECTIVENESS; RESOURCE EFFICIENCY**

"Capio Lundby Sjukhus är ett specialistsjukhus med ambitionen att bedriva vård med hög medicinsk kvalitet och personlig omhändertagande. Genom samlad kompetens, tillgänglighet och kontinuitet får patienten resurseffektiv vård på rätt nivå."
"Som en del av sjukvårdsutbudet i Västra Götaland strävar vi efter samverkan med den övriga sjukvården i Göteborg och övriga Västsverige. Som privatsjukhus har vi även andra kunder, t ex företagshälsovård, försäkringskassa, försäkringsbolag och privatbetalande patienter."

HEALTH SYSTEM PARTICIPATION
"Vi erbjuder hög tillgänglighet och kontinuitet genom hela vårdkedjan. Via gemensamma vårdprogram har vi ett nära samarbete med såväl primärvården som de stora sjukhusen. Även samarbeten med försäkringsbolag, Försäkringskassan och företagshälsovården har utvecklats."

ACCESSIBILITY; HEALTH SYSTEM PARTICIPATION; COMPLETE HOSPITAL
"Inom verksamheten pågår en ständig kvalitetsutveckling utifrån patientens bästa. Kvalitetsarbetet är vars och ens ansvar med ledningens synliga, engagerade och uthålliga stöd. Vår vision är att den vård vi erbjuder ska fokusera på patientens behov och önskemål samt skapa respekt och tilit till oss som vårdgivare."

CONSTANT IMPROVEMENT; QUALITY; BUSINESS CONCEPTS; TRUST; PATIENT INFLUENCE

12/2/13

"Välkommen till oss!
Ditt närsjukhus på Hisingen."

WELCOMENESS
"Välkommen till specialistsjukhuset Capio Lundby Närsjukhus
Capio Lundby Närsjukhus är ett specialistsjukhus med ambitionen att bedriva planerad vård med hög medicinsk kvalitet och personligt omhändertagande. Genom samlad kompetens, tillgänglighet och kontinuitet får patienten resurseffektiv vård på rätt nivå."

COMPETENCE; ACCESSIBILITY; RESOURCE EFFICIENCY; EFFECTIVENESS; PERSONAL CARE; SPECIALIST CARE; AMBITION
"Så här blir du patient hos oss
Utöver vårt avtal med Västra Götalandsregionen har vi även möjlighet att ta emot dig som bor och tillhör andra landsting. I samråd med ditt hemlandsting kan du själv välja var du vill få din specialistvård. Läs mer om hur du ska gå till väga och vad som gäller för just ditt hemlandsting."

HEALTH SYSTEM PARTICIPATION

53
"Vi erbjuder effektiv vård samlad kompetens, tillgänglighet och kontinuitet."
COMPETENCE; ACCESSIBILITY; EFFECTIVENESS; RESOURCE EFFICIENCY
"Capio Lundby Sjukhus är ett specialistsjukhus med ambitionen att bedriva vård med hög medicinsk kvalitet och personlig omhändertagande. Genom samlad kompetens, tillgänglighet och kontinuitet får patienten resourceffektiv vård på rätt nivå."
COMPETENCE; PERSONAL CARE; SPECIALIST CARE; ACCESSIBILITY; RESOURCE EFFICIENCY; EFFECTIVENESS
"Som en del av sjukvårdsutbudet i Västra Götaland strävar vi efter samverkan med den övriga sjukvården i Göteborg och övriga Västsverige. Som privatsjukhus har vi även andra kunder, t ex företagshälsovård, försäkringskassa, försäkringsbolag och privatbetalande patienter."
HEALTH SYSTEM PARTICIPATION
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CONSTANT IMPROVEMENT; QUALITY; BUSINESS CONCEPTS; TRUST; PATIENT INFLUENCE
"Psykiatrisk vård med korta väntetider."
WAITING TIMES
"Hos oss är hela människan i fokus."
EQUITY; PLEASANTNESS

Capio St. Göran Hospital

3/11/05

"Capio S:t Görans ledstjärna.
Capio S:t Görans Sjukhus strävar efter att alltid ligga steget före. Läs mer om Capio S:t Görans verksamhetsidé."
CONSTANT IMPROVEMENT; EXCELLENCE; BEST
"Capio S:t Görans Sjukhus- ett rökfritt sjukhus."
NO SMOKING POLICY
"Hur lång är väntetiden på akuten? Kolla på Akuten on-line."
WAITING TIMES
"Saknar du något på webbplatsen? E-posta dina synpunkter till info@capiostgoran.se."
PATIENT INFLUENCE
"Capio S:t Görans Sjukhus är ett medelstort akutsjukhus som ligger på Kungsholmen. Sedan 1889 har sjukhuset funnits på platsen."
TRADITION
"Vi är ett av sju akutsjukhus i Stockholms län. Den huvudsakliga inriktningen är akut bassjukvård- internmedicin, ortopedi och kirurgi."
HEALTH SYSTEM PARTICIPATION; COMPLETE HOSPITAL
"Vi är en del av den svenska och europeiska sjukvårdskoncernen Capio."
INTERNATIONAL PROFILE
"På Capio S:t Görans Sjukhus är alla människor lika värda, det vill säga att alla blir respekterade för det man är, beroende av det man har, kan eller gör."
EQUITY
"Vårt förhållningssätt innebär att vi respekterar varje människas behov och självbestämmande. Människan får inte kränkas i sin värdighet."
EQUITY
"Om du har synpunkter eller idéer om hur vi kan förbättra informationen på vår hemsida är du välkommen att skicka dem till info@capiostgoran.se."
PATIENT INFLUENCE
"Capio i Sverige och Europa"
INTERNATIONAL PROFILE
"Ekonomiskt resultat"
RESOURCE EFFICIENCY
"Kvalitetsarbete"
QUALITY; CONSTANT IMPROVEMENT

12/2/13

"Välkommen till Capio S:t Görans Sjukhus
"Välkommen till Capio S:t Görans Sjukhus
Akutsjukhuset mitt i stan."


"Välkommen till Capio S:t Göran- ett unikt akutsjukhus!"

"Visste du att Capio S:t Görans Sjukhus är miljöcertifierat?"

"Läs vår kvalitetsredovisning."
Carlanderska erbjuder hälso- och sjukvård där närhet, tillgänglighet och mångfald är våra viktigaste ledord. Vår ambition är att erbjuda personlig vård med närhet till både patienter och vårdköpare.

ACCESSIBILITY; CLOSENESS; DIVERSITY; AMBITION; PERSONAL CARE; TRUST
"Ett av de viktigaste kriterierna för hög vårdkvalitet är tillgänglighet. Därför står vi beredda att ta emot patienter i stort sett närelst det är nödvändigt. Vi kan ofta ordna et besök med några dagars varsel."

ACCESSIBILITY

GENERALIST CARE; SPECIALIST CARE
"Certifiering & ackreditering"
CERTIFICATION

12/2/13

"Välkommen till Carlanderska- möjligheternas sjukhus."
WELCOMENESS; POSSIBILITIES
"Vi erbjuder personlig vård med närhet till både patienter och vårdköpare."
PERSONAL CARE; CLOSENESS
"Vi är en del av sjukvårdssystemet i Västra Götaland. Därför har vi en nära samverkan med den offentliga vården såväl som med försäkringsbolag, enskilda företag och privatpersoner."
HEALTH SYSTEM PARTICIPATION
"Vi har närmare 150 specialistläkare knutna till oss; alla med en gedigen erfarenhet och med en bredd som ger oss möjlighet att upprätthålla vår ambition om det kompletta sjukhuset med väl fungerande vårdkedjor under ett och samma tak."
AMBITION; EFFECTIVENESS; EXPERIENCE; COMPLETE HOSPITAL
"Vår affärsidé
Att tillsammans med våra partners bedriva förstklassig sjukvård så att patienter och beställare ser Carlanderska som ett förståndsvalet."
BUSINESS CONCEPTS; BEST
"Certifiering & ackreditering"
CERTIFICATION
Packaged text content...
"Ersta diakoni ska vara en utmanande aktör som inte vända bort blicken för mänsklig nöd eller tvekar inför svåra uppgifter."

AMBITION; MORAILTY
"Professionellt driven sjukvård och socialt arbete tillsammans med en högskola ger oss unika förutsättningar att ta nya initiativ när det blir luckor i välfärdsstystemet."

SOCIAL WORK; PROFESSIONALISM; EDUCATION
"Vi är en fristående organisation som drivs utan vinstsyfte. Den stora delen av finansieringen för daglig verksamhet kommer numera från avtal med stat, landsting, kommun och kyrka."

NON-PROFIT
"Vision, verksamhetsidé och personalidé

Vision
Ersta diakoni ska se, identifiera och arbeta för och med människor vilkas livskvalitet och människovärde är hotat.

Verksamhetsidé
Ersta diakoni ska utifrån en kristen humanistisk grundsyn vara en diakonal mötesplats som utan vinstintresse bedriver modellskapande häls- och sjukvård, socialt arbete, utbildning och forskning. Ersta diakoni ska känetecknas av diakonalt engagemang, etisk medvetenhet, professionalitet och öppenhet för kulturell mångfald.

Personalidé
Ersta diakonis medarbetare ska utvecklas både i sin yrkesroll och som individer."

BUSINESS CONCEPTS; EDUCATION; MORALITY; NON-PROFIT; SOCIAL WORK; R&D; ETHICS; PROFESSIONALISM; DIVERSITY; CONSTANT DEVELOPMENT

12/2/13

"Ersta diakoni är en ideell förening som bedriver sjukvård, socialt arbete, utbildning och forskning professionellt och non-profit. Verksamheten vilar på en kristen grund och vi hjälper människor i utsatta livssituationer."

NON-PROFIT; SOCIAL WORK; R&D; PROFESSIONALISM; EDUCATION
"Välj vård på Ersta sjukhus
Ersta sjukhus är ett offentligt finansierat sjukhus som drivs utan vinstkrav. Du betalar patientavgift enligt landstingets taxa."

NON-PROFIT
"Miljöarbete"
ENVIRONMENT
"Ersta sjukhus erbjuder somatisk vård där du som patient kommer från vårdgivare över hela länet- och under vårdgarantin även från
andra närliggande län. Vi tar inte emot akuta besök, för att komma hit krävs normalt att du har en remiss för att du ska komma till rätt avdelning och få rätt vård eller undersökning utförd." 
EFFECTIVENESS
"Vision
Vi ser människan."
TRUST; BUSINESS CONCEPTS
"Verksamhetsidé
Ersta diakoni är en ideell förening som bedriver sjukvård, omsorg samt forskning och utbildning, professionellt och non-profit."
NON-PROFIT; R&D; PROFESSIONALISM; BUSINESS CONCEPTS

Sophiahemmet Hospital

24/11/05

"Välkommen till Sophiahemmet."
WELCOMENESS
"Sophiahemmet är det privata sjukhuset för personlig och professionell omvårdnad. Vår mer än hundraåriga tradition är grunden för utveckling av modern sjukvård i en varm och trygg omvårdnadsmiljö."
PERSONAL CARE; PROFESSIONALISM; TRADITION; MODERNITY; TRUST; EXPERIENCE; CONSTANT IMPROVEMENT
"Vårt mått på kvalitet
För oss är kvalitet att patienten är nöjd. Därför undersöker vi regelbundet vad patienterna tycker om vården. Synpunktarna hjälper oss att växa."
QUALITY; EVALUATION; PATIENT INFLUENCE
"Sjukvård
EFFECTIVENESS; PLEASANTNESS; COMPETENCE; TRUST
"Sophiahemmet är det privata sjukhuset för specialistvård och särklang omvårdnad. Vår mer än hundraåriga tradition är grunden utveckling av modern sjukvård i en varm och trygg omvårdnadsmiljö.

Vi erbjuder en bredd av kunnande och hos oss finns några av landets främsta specialister. En del av dem är också forskare och bidrar till att utveckla nya medicinska behandlingsmetoder. De framsteg som görs kan komma våra patienter till nytta. Inom Sophiahemmet har vi tillgång till högteknologisk utrustning inom diagnostik och behandling."

"En god sjukhusmiljö där det finns tid för varje enskild patient är viktigt för ett snabbt tillfrisknande. På Sophiahemmet vill vi uppfylla vars och ens behov."

"Kännetecknande för vår verksamhet är tillgänglighet, kontinuitet och hög kvalitet till rätt pris."

"Till Sophiahemmet kommerpatienter från alla delar av landet och även andra länder för att få vård. Den betalas av landsting, patienten själv eller ett försäkringsbolag. Vi ger samma vård och behandling till alla oavsett vem som betalar."
27-åriga Alfhild Ehrenborg, skolad hos Miss Nightingale. På grund av samarbetssvårigheter med stadens sjukhus, lade Drottning Sophia och hennes gemål Oscar II den 14 december 1887 grundstenen till ett helt nytt sjukhus och sköterskehem. Inom två år, den 1 oktober 1889, kan det nya sjukhuset och elevhemmet invigas och med gyllene bokstäver låter Drottning Sophia inrista "Allt till Guds ära" i den stora entrén. Den för Sophiasystrar så välkända mössan representerar enligt muntlig tradition- det vita tyget det ljusa i livet, det svarta bandet allvaret i livet, spetsenäsidaden i livet och vecken på mössan tio Guds bud och vecken på spetsen tinnarna i Drottning Sophias krona."

TRADITION

Akademiska University Hospital

13/10/05

"Akademiska är ett av Sveriges största sjukhus. En del säger att det är bra att det inte är så stort. De som är vana att besöka stora sjukhus blir ibland förvånade när de kommer till Akademiska i Uppsala. Det känns inte så stort, säger vissa. Lite vänligare och lite lugnare, säger andra som tidigare mött stortstadsmentaliteten även i sjukvården. Ändå kvarstår faktum: Akademiska är det äldsta och ett av de största universitetssjukhusen i Sverige. Men upplevelsen av att vi är ett lite mindre sjukhus där det fortfarande finns utrymme för en personlig kontakt är vi stolta över. Och angelägna om att bevara." SMALLNESS; KINDNESS; PLEASANTNESS; EXPERIENCE; TRADITION; PERSONAL CARE; PROFESSIONALISM

"Akademiska har många roller- länssjukhus, specialistsjukhus, utbildningssjukhus och forskningssjukhus. I vardagen flyter de olika rollerna ihop. På så sätt uppstår förutsättningen för, och förklaringen till, den erfarenhet, kompetens och omtanke som finns här."

REGIONAL ROLE; EXPERIENCE; COMPETENCE; EMPATHY; R&D; EDUCATION

12/2/13

"Akademiska har många roller- länssjukhus, specialistsjukhus, utbildningssjukhus och forskningssjukhus. I vardagen flyter de olika rollerna ihop. På så sätt uppstår förutsättningen för, och förklaringen till, den erfarenhet, kompetens och omtanke som finns här."

REGIONAL ROLE; EXPERIENCE; COMPETENCE; EMPATHY; R&D; EDUCATION

"Akademiska sjukhuset har circa 1100 vårdplatser och under 2011 registrerades cirka 60000 vårdtillfällen. Drygt 25 procent av dessa
vårdtillfällen var vård som såldes till andra landsting i regionen eller riket. Vidare besökte drygt 650000 patienter sjukhuset för öppenvårdsbesök och 30000 operationer genomfördes.
2011 hade sjukhuset en omsättning på 7,1 miljarder kronor, varav 1,7 miljarder var vård som såldes till andra landsting.
På sjukhuset arbetar drygt 8000 personer, varav 1247 läkare och 2697 sjuksköterskor och barnmorskor.
Vill du veta mer om vården på Akademiska sjukhuset i förhållande till andra sjukhus- läs rapporten Öppna jämförelser från SKL.

Enköping Hospital

24/10/05
"Vårdgaranti"
WAITING TIMES

12/2/13
"Välkommen till Lasaretet i Enköping
Vi finns här för att hjälpa dig på bästa sätt och hos oss ska du som patient alltid känna trygghet i hög medicinsk standard och god omvårdnad av kompetent personal."
WELCOMENESS; COMPETENCE; TRUST; PERSONAL CARE
"Om lasaretet
Här finns information för dig som vill veta lite mer om lasaretet; vad vi har för vision och verksamhetsidé eller hur vår organisation ser ut.
Kanske vill du se vår senaste ekonomiska rapport eller veta vilka som är lasaretets chefer?"
REPORTING; QUANTIFICATION; RESOURCE EFFICIENCY; BUSINESS CONCEPTS
"Lasaretet i Enköping är ett länsdels- och akutsjukhus för södra länsdelen. Verksamheten drivs i nära samarbete med Akademiska sjukhuset och Håbo och Enköpings kommuner."
HEALTH SYSTEM PARTICIPATION
"Lasaretet ger klinisk utbildning för blivande läkare, sjuksköterskor och annan sjukvårdspersonal."
EDUCATION

Karolinska University Hospital

20/10/05

"Framtidens sjukvård genom vetenskap och utveckling."
MODERNITY; R&D

"Sammanslagningen har inneburit att hög kompetens och avancerade resurser från två starka universitetssjukhus har samlats under en ledning. Detta öppnar för möjligheten att skapa ett modernt universitetssjukhus som arbetar i ett internationellt perspektiv."
COMPETENCE; MODERNITY; INTERNATIONAL PROFILE

"Verksamhetens omfattning och innehåll
Det nya universitetssjukhuset är ett av de största i Europa med totalt 1700 vårdplatser. År 2005 kommer cirka 98300 vårdtillfällen att produceras varav 5300 är vårdtillfällen som härrör från utomläns- eller utlandspatienter. Vidare producerar Karolinska cirka 1,3 miljoner besök varav 39000 besök är utomläns- eller utlandspatienter. Omsättningen uppgår 2005 till 10,1 miljarder och antalet anställda är ca 15100."
QUANTIFICATION; INTERNATIONAL PROFILE; EUROPEAN LEADER

REGIONAL ROLE; AMBITION; EDUCATION; COMPETITIVENESS; RELEVANCE; R&D

"Sammanslagningen av två starka universitetssjukhus har inneburit att hög kompetens och avancerade resurser har samlats under en ledning. Detta öppnar för möjligheten att skapa ett modernt universitetssjukhus som arbetar i ett internationellt perspektiv. Samordningen av verksamheter mellan sjukhusen innebär att det uppstår synergieffekter, t ex i form av större patientunderlag för främjande av forskning och utveckling, främjande av gemensamma vårdprogram, bättre ekonomi genom att man kan dela på och koncentrera resurser, lägre andel administrativa kostnader och bättre ledningsstruktur. Under 2004 och 2005 är det interna arbetet inriktat på att ta tillvara dessa positiva effekter samt utveckla strategin för framtiden."
COMPETENCE; MODERNITY; INTERNATIONAL PROFILE; RESOURCE EFFICIENCY; R&D

"Sjukhuset bedrivs under bolagsliknande former och har en egen styrelse".
"Välkommen till Karolinska Universitetssjukhuset
Karolinska Universitetssjukhuset är ett av Europas största sjukhus och tillsammans med Karolinska Institutet driver vi den medicinska utvecklingen i Sverige. För oss är sjukvård, forskning och utbildning lika viktiga delar i arbetet för att förlänga och förbättra människors liv.
WELCOMENESS; INTERNATIONAL PROFILE; BIG; NATIONAL LEADER; MODERNITY; R&D; LIFE IMPROVEMENT; EDUCATION
"Patientsäkerhet
Vårt mål är att alla patienter ska få en god och säker vård av hög kvalitet."
QUALITY; TRUST
"Karolinska Universitetssjukhuset är ett av Europas största universitetssjukhus. I vår verksamhet ryms sjukvård som omfattar både de stora folksjukdomarna och mer sällsynta sjukdomstillstånd."
INTERNATIONAL PROFILE; SPECIALIST CARE; GENERALIST CARE
"I Stockholmsregionen har vi ett särskilt ansvar att tillhandahålla högspecialiserad sjukvård. Vi tar även emot många patienter från andra delar av landet och också från andra länder."
SPECIALIST CARE; INTERNATIONAL PROFILE
"Fakta om sjukhuset
Cirka 1736 vårdplatser
Cirka 108400 vårdtillfällen i sluten vård
Cirka 1,4 miljoner besök i öppen vård
Antal anställda ca 15500
Omsättning 2007- 11,4 miljarder
Omsättning 2008- 12,2 miljarder
Omsättning 2009- 13,2 miljarder
Omsättning 2010- 14,2 miljarder
Omsättning 2011- 14,7 miljarder"
QUANTIFICATION
"Våra medarbetare är vår viktigaste resurs- vår kompetens består av medarbetarnas skicklighet i att bedöma patienten och förmåga
ge vård av högsta kvalité och säkerhet. Karolinska arbetar ständigt med att utveckla och förbättra vård och arbetsmetoder."

CONSTANT IMPROVEMENT; COMPETENCE; QUALITY; TRUST

"Hos oss är patienten alltid i fokus, vilket innebär att vi ger kvalitativ och säker vård, ser till att våra patienter får ett personligt bemötande och vi omsätter forskning, utbildning och utveckling till vården. På Karolinska Universitetssjukhuset tar vi ansvar för varandra och våra patienter. Vi bemöter varandra med omtanke och respekt och vi arbetar tillsammans över gränser för att ge bästa möjliga vård."

TRUST; RESPONSIBILITY; KINDNESS; RESPECT; R&D; EDUCATION

"Flödesarbetet"
BUSINESS CONCEPTS
"Vår vision"
BUSINESS CONCEPTS
"Miljöcertifierat"
ENVIRONMENT; CERTIFICATION

"Här kan du som besökare ta del av sjukhusets olika styrdokument under de år som har gått på Karolinska Universitetssjukhuset."

TRANSPARENCY

Söder Hospital

29/7/05

"En halv miljon Stockholmare har Södersjukhuset som sitt akutsjukhus och cirka 3700 personer har sjukhuset som sin arbetsplats. Här finns norra Europas största akutmottagning, vilket präglar hela verksamheten."

QUANTIFICATION; COMPARISON

"Till Södersjukhuset kommer ungefär 87000 patienter varje år för att få akut hjälp med allt från benbrott till hjärtinfarkter. Sachsska Barnsjukhusets akutmottagning tar emot cirka 17000 besök per år. På Södersjukhuset föds cirka 5400 barn årligen och cirka 47000 patienter läggs in varje år på någon av sjukhusets avdelningar."

QUANTIFICATION

"Specialisering på de stora folksjukdomarna
Södersjukhuset har på många sätt präglats av sin omgivning och befolkningens behov. Det stora patientunderlaget har möjliggjort Södersjukhusets specialisering på de stora folksjukdomarna, som till exempel diabetes, hjärt- /kärlsjukdomar och höftfrakturer. På Södersjukhuset bedrivs också en omfattande forskning med tonvikt på folksjukdomar. På sjukhusets kliniker utbildas blivande
sjuksköterskor, läkare, sjukgymnaster, arbetsterapeuter och andra vårdstudenter för sin kommande yrkesroll.

COMPETENCE; EDUCATION
"SÖS i siffror"
QUANTIFICATION
"Konst på SÖS"
PLEASANTNESS
"Aktiebolag
BUSINESS CONCEPTS

12/2/13

"Hela livets sjukhus" 
COMPLETE HOSPITAL; COMPETENCE
"Välkommen till Södersjukhuset
Södersjukhuset i Stockholm har en av Nordens största akutmottagningar. Akutsjukvård står i centrum för vår verksamhet och utgör tillsammans med de stora folksjukdomarna sjukhusets specialitet.
WELCOMENESS; COMPARISON; COMPETENCE
"För oss är det viktigt att kombinera det stora sjukhusets möjligheter med den nära patientkontakten och se till att leva upp till våra ledord: "för patienten- med patienten""
TRUST; PERSONAL CARE
"Livets mirakel på BB SÖS!
TRUST; PERSONAL CARE
"Forskning på Södersjukhuset
På sjukhuset finns omfattande forskning och utbildning inom Institutionen för klinisk forskning och utbildning, KI SÖS. Forskningen är inriktad på den kliniska verksamheten och bidra till att utveckla och förbättra det akuta omhändertagandet av svårt skadade och sjuka.
R&D; EDUCATION; CONSTANT IMPROVEMENT
"Akutmottagningar & väntetidsinformation"
WAITING TIMES
"Patientsombudsmannen"
PATIENT INFLUENCE; EVALUATION
"Lex Maria"
REPORTING
"Patientjournaler och kopior"
TRANSPARENCY
"Patientsombudsmannen"
PATIENT INFLUENCE; EVALUATION
"Patientsäkerhetsberättelse"
TRANSPARENCY
"SÖS miljöarbete"
ENVIRONMENT; CONSTANT IMPROVEMENT
"En halv miljon Stockholmare har Södersjukhuset som sitt akutsjukhus och 4300 personer har sjukhuset som sin arbetsplats."
QUANTIFICATION
"Till Södersjukhuset kommer ungefär 100000 patienter varje år för att få akut hjälp med allt från benbrott till hjärtinfarkter. Sachsska barn- och ungdomssjukhusets akutmottagning tar emot cirka 20000 besök per år. På Södersjukhuset föds mer än 7000 barn årligen och cirka 52000 patienter läggs in varje år på någon av sjukhusets avdelningar."
QUANTIFICATION
"Specialisering på de stora folksjukdomarna
COMPETENCE; EDUCATION; R&D
"Aktiebolag
Vid årsskiftet 2001/2002 blev Södersjukhuset aktiebolag, till 100 procent ägt av Stockholms läns landsting. Södersjukhusets organisatonsnummer är 55 65 95-7403."
BUSINESS CONCEPTS
"SÖS i siffror 2012
4311 anställda
649 vårdplatser
7298 förlossningar
123676 sökande vid akutmottagningen för vuxna
25034 sökande vid Sachsska barn- och ungdomssjukhusets akutmottagning
389928 registrerade öppenvårdskontakter
52426 inläggningar på våra avdelningar
Omsättning: 3,8 miljarder kronor."

QUANTIFICATION

Danderyd Hospital

3/9/05

"Danderyds Sjukhus
Kvalitet och omtanke."
QUALITY; EMPATHY

12/2/13

"Kvalitet
Det viktigaste för oss på Danderyds sjukhus är att du som patient känner dig trygg och säker. Vår kompetens ska garantera så god vård och behandling som möjligt."
QUALITY; COMPETENCE; RESPONSIBILITY

"Om sjukhuset
Danderyds sjukhus är ett av de större akutsjukhusen i Sverige och är, tillsammans med hälftenägda BB Stockholm, norra Europas största förlossningssjukhus."
COMPARISON; BIG

"Danderyds Sjukhus AB är ett helägt dotterbolag till Landstingshuset i Stockholm AB, med specialistvård med huvudsaklig inriktning på internmedicin, kardiologi, ortopedi, obstetrik och gynekologi, kirurgi samt urologi."
SPECIALIST CARE
"Utbildning
Forskning"
R&D; EDUCATION
"Miljöarbete"
ENVIRONMENT
"Kvalitetsarbete"
QUALITY; CONSTANT IMPROVEMENT
"I framkant
Sjukhusets strokevård hör till landets främsta och Danderyds sjukhus ligger bäst till bland Stockholmssjukhusen när det gäller
operation inom 24 timmar av patienter med höftfrakturer. På sjukhuset finns även Stockholms största talklinik, ett nationellt
respirationscentrum och Sveriges största universitetsklinik för rehabiliteringsmedicin."
EXCELLENCE; COMPETENCE; SPECIALIST CARE
"Till sjukhusets spetsområden hör bland annat komplicerade axel- och höftledsoperationer, överviktsoperationer och en
högkvalificerad vård och rehabilitering av patienter med hjärtproblem."
SPECIALIST CARE
"Vision och värderingar
Vår vision är att vara Norra Stockholms akutsjukhus- vänligt och proffsigt, smidigt och säkert."
BUSINESS CONCEPTS; KINDNESS; PROFESSIONALISM
"Våra grundläggande värderingar är att med kvalitet och omtanke:
Ge sjukvård på lika villkor utifrån patientens behov
Visa respekt för individen
Ta ansvar för att utveckla och förbättra vården."
BUSINESS CONCEPTS; RESPECT; QUALITY; EMPATHY; EQUITY; PATIENT INFLUENCE; CONSTANT IMPROVEMENT

St. Erik Hospital

26/10/05

"Välkommen till S:t Eriks Ögonsjukhus"
WELCOMENESS
"Verksamheten vid S:t Eriks Ögonsjukhus
S:t Eriks Ögonsjukhus bedriver både planerad och akut ögonsjukvård. Årligen genomförs 175000 planerade och akuta patientbesök vid S:t Eriks. Sjukhuset är beläget i Stockholm men patienterna kommer från hela Sverige och från utlandet." SPECIALIST CARE; QUANTIFICATION; NATIONAL PROFILE; INTERNATIONAL PROFILE
"S:t Eriks Ögonsjukhus har ett stort inslag av forskning, utveckling och undervisning, vilket är positivt för såväl patienter som sjukhusets personal. S:t Eriks Ögonsjukhus har 350 anställda och drivs som ett aktiebolag med ett Stockholms läns landsting som ägare." R&D; EDUCATION; BUSINESS CONCEPTS; COMPETENCE
"S:t Eriks Ögonsjukhus AB miljöcertifierades redan år 2000, som ett av de första sjukhusen i Sverige." ENVIRONMENT; CERTIFICATION 
"Miljö- och kvalitetsarbete" QUALITY; ENVIRONMENT; CONSTANT IMPROVEMENT
"Vårdutveckling" CONSTANT IMPROVEMENT
12/2/13

"S:t Eriks Ögonsjukhus
S:t Erik är ett av Europas ledande ögonsjukhus."
EUROPEAN LEADER; COMPARISON; INTERNATIONAL PROFILE
"Hjälp oss att bota fler!
Ingenting är omöjligt. Vi vill kunna behandla och bota alla ögonsjukdomar som finns. Men medicinsk forskning kostar pengar. Du kan kanske hjälpa oss att nå våra mål?"
AMBITION
"Om S:t Eriks Ögonsjukhus
S:t Eriks Ögonsjukhus är ett av Europas ledande ögonsjukhus."
EUROPEAN LEADER; COMPARISON; INTERNATIONAL PROFILE
"S:t Eriks Ögonsjukhus är unikt i Sverige som det enda sjukhuset inriktat på ett enda organ, ögat. Här erbjuder vi planerad och akut ögonsjukvård, högkvalitativ forskning och bred utbildning." SPECIALIST CARE; R&D; EDUCATION
"Varje dag möter vi patienter från Stockholms län, Sverige och utlandet. Vi har cirka 200000 patientbesök per år. Sjukhuset har 360
medarbetare och drivs som ett aktiebolag med Stockholms läns landsting som ägare."

"Snabbfakta
162878 besök i öppenvård
1654 vårdtillfällen i slutenvård
30729 besök på akuten
11000 operationer
19947 ögonbottenfotograferingar
Omsättning: 410 miljoner kronor."

"Vision och verksamhetsidé"
BUSINESS CONCEPTS
"Internationella samarbeten"
INTERNATIONAL PROFILE
"Forskning"
R&D
"Utbildning"
EDUCATION
"Kvalitetsarbete"
QUALITY; CONSTANT IMPROVEMENT
"Miljöarbete"
ENVIRONMENT

**Sahlgrenska University Hospital**

13/10/05

12/2/13

"Forskning i samarbete
Sahlgrenska Universitetssjukhuset har ett unikt samarbete med Sahlgrenska akademin, den hälsovetenskapliga fakulteten vid

R&D
"Sahlgrenska Universitetssjukhuset är ett hälsofrämjande och rökfritt sjukhus. På våra sjukhusområden är rökning endast tillåten på anvisade platser."

NO SMOKING POLICY

"Om Sahlgrenska Universitetssjukhuset
Kompetens och omtanke
På Sahlgrenska Universitetssjukhuset finns kompetensen att utföra de allra mest avancerade behandlingar och ingrepp som dagens medicinska utveckling tillåter. Samtidigt är omtanken och omvårdnaden om patienten vårt främsta fokus. För att kunna garantera kvalitet är ständig utveckling och förbättring ett viktigt mål. Som ett av landets största universitetssjukhus har vi närheten till allt det som erbjuds inom utbildning och forskning på Sahlgrenska akademin vid Göteborgs universitet."

COMPETENCE; EMPATHY; CONSTANT IMPROVEMENT; R&D; EDUCATION

"Bredd och djup

REGIONAL ROLE; CUTTING-EDGE KNOWLEDGE; COMPETENCE; SPECIALIST CARE; QUANTIFICATION

"Uppdrag och vision"
BUSINESS CONCEPTS
"Så tycker våra patienter"
PATIENT INFLUENCE
"Kvalitetsdagarna"
QUALITY
"En vanlig dag på sjukhuset
30 förlossningar
500 akutbesök"
2200 läkarbesök
16700 labbanalyser"
QUANTIFICATION
"Sjukhuset i siffror
Vårdplatser: 2000
Vårdavdelningar öppenvård: 170
Vårdavdelningar slutenvård: 140
Medarbetare: 16057 varav 1021 timanställda (30 mars 2012)
Kliniska utbildningsplatser: 1600
Omsättning: 12.3 miljarder kr
Resultat 2010: +34 miljoner kr"
QUANTIFICATION
"Årsredovisning 2011
Årsredovisning 2010
 Patientsäkerhetsberättelse 2011"
TRANSPARENCY

NU Hospital

25/11/05

"Välkommen till NU-sjukvården"
WELCOMENESS
"Vårdgaranti 05"
WAITING TIMES
"Inom NU-sjukvården är över 80% av sjukhusvården akut.
Totalt arbetar ca 5500 personer i NU-sjukvården. Budgeten för 2004 är ca 3,2 miljarder kronor."
QUANTIFICATION

12/2/13
"Välkommen till NU-sjukvården"
WELCOMENESS
"Våra 5000 medarbetare erbjuder specialiserad vård och närsjukvård av hög kvalitet till 275000 invånare i Fyrbodalsområdet."
SPECIALIST CARE; GENERALIST CARE; QUALITY
"Om oss
NU-sjukvården är en av sjukhusgrupperna i Västra Götalandsregionen och består av fem sjukhus: de båda större sjukhusen Norra Älvsborgs läns sjukhus (NÄL) och Uddevalla sjukhus, samt lokalsjukhusen i Lysekil, Strömmmstad och Dalsland. Våra 5000 medarbetare erbjuder specialiserad vård och närsjukvård av hög kvalitet till de 270000 invånarna i Fyrbodalsområdet."
SPECIALIST CARE; GENERALIST CARE; QUALITY
"De senaste åren har omfattande verksamhetsförändringar gjorts för att inrikta NÄL mot den breda akutsjukvården och Uddevalla sjukhus mot mer planerad vård (projektet benämndes Vård 2010). Det är ett led i NU-sjukvårdens utvecklingsarbete för att, med patientens bästa i fokus, förbättra kvalitet och effektivitet." CONSTANT IMPROVEMENT; RESOURCE EFFICIENCY; PERSONAL CARE; QUALITY; EFFECTIVENESS
"NU-sjukvårdens verksamhetsidé:
Vi erbjuder invånarna i Fyrbodal specialiserad akut- och planerad vård samt närsjukvård av hög kvalitet genom att arbeta processorierterat och i samverkan med vårdgrannar. Vi arbetar utifrån God Vård, det vill säga säker vård, patientfokuserad vård, kunskapsbaserad vård, jämlik vård, vård i rimlig och effektiv vård."
BUSINESS CONCEPTS; QUALITY; PERSONAL CARE; COMPETENCE; EQUITY; RESOURCE EFFICIENCY
WAITING TIMES
"NU-sjukvårdens vision är:
Ett sjukhus i ständig utveckling för patientens bästa.
Med detta menas att patienten möts av en tillgänglig, konkurrenskraftig och kunskapsbaserad specialistvård i ständig utveckling."
BUSINESS CONCEPTS; CONSTANT IMPROVEMENT; PERSONAL CARE; COMPETENCE; ACCESSIBILITY

Skaraborg Hospital

19/11/05

"Sjukhuset har verksamhet på fyra orter i Skaraborg; Falköping, Lidköping, Mariestad och Skövde. Vid sjukhuset finns ett 30-tal medicinska specialiteter, de flesta är samlade vid Kärnsjukhuset i Skövde. Sjukhuset i Lidköping har en självständig ledning, men ingår i gruppen Skaraborgs sjukhus."
SPECIALIST CARE

"Fakta om sjukhuset:
Fakta- statistik om sjukhuset."

QUANTIFICATION

12/2/13

"Välkommen till Skaraborgs Sjukhus
Skaraborgs sjukhus består av Skaraborgs Sjukhus Falköping, Skaraborgs Sjukhus Lidköping, Skaraborgs Sjukhus Mariestad samt Skaraborgs Sjukhus Skövde. Vi ger specialistvård inom ett 30-tal specialiteter."

WELCOMENESS; SPECIALIST CARE

"Vår vision är "God vård i utveckling" och här arbetar cirka 4400 medarbetare för att ge Västra Götalandsregionens invånare i närområdet en god och säker vård."

BUSINESS CONCEPTS; CONSTANT IMPROVEMENT

"Om Skaraborgs Sjukhus
Skaraborgs Sjukhus har verksamhet på fyra orter i Skaraborg; Falköping, Lidköping, Mariestad och Skövde.
Skaraborgs Sjukhus Skövde
Skaraborgs Sjukhus Skövde är den största enheten inom Skaraborgs Sjukhus.
Skaraborgs Sjukhus Falköping
Skaraborgs Sjukhus Falköping erbjuder specialiserad vård inom kirurgi, ortopedi, internmedicin och psykiatri.
Skaraborgs Sjukhus Lidköping
Skaraborgs Sjukhus Lidköping är, liksom Skaraborgs Sjukhus Skövde ett akutsjukhus med jourbemanning, vårdavdelningar och mottagningar.
Skaraborgs Sjukhus Mariestad
På sjukhuset i Mariestad finns mottagningar inom flertalet specialiteter."

SPECIALIST CARE

"Verksamhetsidé"

BUSINESS CONCEPTS

"Vision och värdegrund"

BUSINESS CONCEPTS

"Korta fakta om Skaraborgs Sjukhus
(Enligt årsredovisning 2011)
Anställda
Skaraborgs Sjukhus har cirka 4500 anställda (tillsvidareanst, visstidanst och timavlönade)

Vårdplatser
Skaraborgs Sjukhus har 741 vårdplatser fördelade på följande orter:
Skaraborgs Sjukhus Falköping:
134 vårdplatser
Skaraborgs Sjukhus Lidköping:
134 vårdplatser
Skaraborgs Sjukhus Mariestad:
16 vårdplatser
Skaraborgs Sjukhus Skövde:
457 vårdplatser

Detta hände under 2011:
ca 354400 besök gjordes inom öppenvården
ca 41000 vårdtillfällen i sluten vård (pat inskriven på vårdavdelning)
20500 operationer gjordes
2377 barn föddes.

QUANTIFICATION

SÄS Hospital

10/12/05

"Arbete och kompetens
Forskning och utveckling
Utbildning"

COMPETENCE; R&D; EDUCATION

"SÄS utför specialiserad sjukvård företrädesvis i Borås och Skene med hjälp av cirka 530 anställda och 4400 vårdplatser. Vid SÄS bedrivs länssjukvård inom alla specialiteter och viss regionsjukvård inom onkologi och strålbehandling."

SPECIALIST CARE; REGIONAL ROLE
"SÄS i siffror"
QUANTIFICATION

12/2/13

"God vård i rimlig tid- om vårdgaranti och valfrihet."
WAITING TIMES; RESOURCE EFFICIENCY
"Ge dina synpunkter på vården
Hjälp oss att bli bättre"
PATIENT INFLUENCE
"Framtidens sjukhus"
MODERNITY
"Miljö"
ENVIRONMENT
"Södra Älvsborgs Sjukhus, SÄS, finns i Borås och Skene och är en av fyra sjukhusgrupper i Västra Götalandsregionen. Vid vårt sjukhus bedrivs länsjukvård inom alla specialiteter och viss regionalsjukvård inom onkologi och strålbehandling. Sjukhusdirektören heter Thomas Wallén."
REGIONAL ROLE
"SÄS är också ett hälsofrämjande sjukhus och vi fokuserar på god behandling och omsorg om patienterna. Vi har också valt en successiv övergång till en processorienterad organisation. Det finns två huvudskäl till varför vi väljer ett processetablerat arbetssätt:
1. Det sätter på ett naturligt sätt patientperspektivet i fokus.
2. Det ger förutsättningar till en förbättringskultur där kontinuerlig uppföljning och analys av uppnådda resultat leder till fortsatt förbättringsarbete."
BUSINESS CONCEPTS; PERSONAL CARE; EMPATHY; CONSTANT IMPROVEMENT
"Vision
SÄS- mitt sjukhus
Visionen beskriver vår framtida önskvärda position och är en gemensam målsättning för alla medarbetare på sjukhuset. Den utgår från var och en av oss och ska kännas nära, oavsett om vi är medborgare, studenter, medarbetare eller patienter.
SÄS vill:
Erbjuda tillgänglig specialiserad vård för ökad livskvalitet
Vara ett attraktivt specialitsjukhus som erbjuder utbildning av hög kvalitet
Vara en arbetsgivare som värdesätter engagemang, delaktighet och utveckling
Vara en trygg vårdgivare med en god vårdmiljö"
BUSINESS CONCEPTS; ACCESSIBILITY; EDUCATION; QUALITY; CONSTANT IMPROVEMENT; SPECIALIST CARE; EQUITY;
AMBITION; TRUST
"Värdegrund
Värdegrunden beskriver vårt gemensamma förhållningssätt och hur vi förväntas utföra vårt arbete. Den genomsyrar allt vi gör för våra patienter.
Mitt handlande och bemötande utgår från respekt och förtroende för patienter, närstående och medarbetare
Min arbetsinsats är viktig för helheten
Jag vill utvecklas, lära nytt och dela med mig av min kunskap."
BUSINESS CONCEPTS; TRUST; CONSTANT IMPROVEMENT; RESPECT
"Verksamhetsidé
SÄS - ett hälsofrämjande sjukhus med god specialiserad vård
Verksamhetsidén förtydligar visionen genom att beskriva vad vi gör.
SÄS är ett specialitsjukhus och erbuder sjukvård som kräver specialiserad kompetens inom både öppen och sluten vård.
Vi är även ett hälsofrämjande sjukhus vilket betyder att vi fungerar som en hälsoresurs och sprider kunskap och ger verktyg för att fördröja eller i bästa fall förhindra ett nytt behov av specialitsjukvård."
BUSINESS CONCEPTS; SPECIALIST CARE; COMPETENCE
"Vårt gemensamma arbetssätt
Nyckeln till vår framgång handlar till stor del om hur vi arbetar och förhåller oss till varandra och våra patienter.
Vi gör patient och närstående delaktiga i vården
Vi arbetar i team och kombinerar process- och linjeorganisation
Vi är en lärande organisation och utvecklas ständigt
Vi samarbetar, använder resurser effektivt och optimerar flöden
Vi arbetar hälsofrämjande för en hållbar framtid
Vi följer upp verksamheten, återkopplar och förbättrar."
PERSONAL CARE; RESOURCE EFFICIENCY; SUSTAINABILITY; CONSTANT IMPROVEMENT;
BUSINESS CONCEPTS; EVALUATION
"Kvalitetsmål
Genom att vi utvecklar vår verksamhet mot de nationella kvalitetsmålen för God Vård kommer vi närmare vår vision."
God Vård
Jämlik
Kunskapsbaserad
I rimlig tid
Säker
Patientfokuserad
Effektiv"
EQUITY; RESOURCE EFFICIENCY; PERSONAL CARE; EFFECTIVENESS

Kungälv Hospital

25/8/05

"Välkommen till Kungälvs sjukhus!
Hälsofrämjande sjukhus
Rökfritt sjukhus"
WELCOMENESS; NO SMOKING POLICY
"Vi erbjuder specialistvård och på sjukhuset finns akutmottagning för internmedicin, kirurgi, ortopedi, geriatrik och psykiatri. Dagtid
har vi dessutom specialistmottagningar för ögon- och öron-näsa-halssjukvård och för kvinnosjukdomar. Det finns en modern
röntgenavdelning och välutrustat laboratorium och blodcentral."

SPECIALIST CARE
"Hos oss arbetar välutbildad och erfaren personal som strävar efter att erbjuda den bästa medicinska vården. Vi samverkar med
kommuner och primärvård i närområdet. Vi arbetar också för att skapa bästa förutsättningar för en framtidig god hälsa för alla. För
personalen vill vi utveckla "Den goda arbetsplatsen" som finns i Västra Götalandsregionen Personalvision 2010."
COMPETENCE; EXPERIENCE; HEALTH SYSTEM PARTICIPATION; AMBITION
"Välkommen till Kungälvs sjukhus- sjukhuset bryr sig om hälsan!"
WELCOMENESS
"Vi kan ge specialitsvård på akutmottagningarna. På en akutmottagning tar man emot personer som behöver hjälp snabbt."

Här finns akutmottagning för sjukdomar inuti kroppen och för ortopedi. Ortopedi är skador och sjukdomar i människans sätt att
Sjukhuset har en modern röntgenavdelning och en blodcentral. På röntgenavdelningen undersöker man hur det ser ut inne i kroppen. Det finns laboratorium och en blodcentral."

SPECIALIST CARE
"Hos oss arbetar personal som har bra utbildning och som är duktig på sina arbetsuppgifter. Personalen vill ge patienterna så bra vård som möjligt."

COMPETENCE
"Vi samarbetar med kommuner och vårdcentraler som ligger nära Kungälv."

HEALTH SYSTEM PARTICIPATION

12/2/13

"Välkommen till Kungälvs sjukhus"

WELCOMENESS
"Kungälvs sjukhus är ett akutsjukhus som bedriver specialistvård inom internmedicin, kirurgi, ortopedi, geriatrik och psykiatri. Här arbetar välutbildad och erfaren personal som strävar efter att erbjuda högsta kvalitet i det medicinska omhändertagandet."

SPECIALIST CARE; QUALITY; AMBITION; COMPETENCE; EXPERIENCE
"Sjukhuset har som mål att ge högsta kvalitet i det medicinska omhändertagandet."

QUALITY
"Kungälvs sjukhus erbjuder specialistvård och här finns akutmottagning för internmedicin, kirurgi, ortopedi, geriatrik och psykiatri. Vid sjukhuset finns även intensivvård, bild- och funktionsmedicin och laboratoriemedicin."

SPECIALIST CARE
"Sjukhuset är ett hälsofrämjande sjukhus. Detta innebär att sjukhuset arbetar aktivt för att hjälpa patienter, personal och befolkningen i närområdet att uppnå en mer hälsofrämjande livstil. Sjukhuset är tobaksfritt sedan flera år."

NO SMOKING POLICY
"Sjukhuset samverkar med kommuner och primärvård i närområdet med inriktning att ha en gemensam helhetssyn för patientens väg genom vården."

HEALTH SYSTEM PARTICIPATION

81
"Korta fakta 2012
Områdesansvar för 118000 invånare
1499 medarbetare
200 vårdplatser samt 10 tillfälliga vårdplatser
11601 vårdfallen inom somatisk slutenvård
988 vårdfallen inom psykiatrisk slutenvård
96288 besök inom öppenvården
Bruttokostnadsomslutning: drygt 1 miljard kronor."

"Miljöarbete"
ENVIRONMENT

Alingsås Hospital

23/12/05

"Välkommen till
Alingsås lasarett
Ditt sjukhus
En modell för framtiden"

WELCOMENESS; MODERNITY; TRUST

"Alingsås lasarett skall i nära samarbete med andra vårdgivare och intresseorganisationer
skapa trygghet dygnet runt för de boende i området.
Bidra till hög tillgänglighet för regionens invånare genom mer planerad vård.
Utveckla och pröva nya arbetssätt."

HEALTH SYSTEM PARTICIPATION; ACCESSIBILITY; CONSTANT IMPROVEMENT

"Alingsås har en strategisk placering mitt i Västra Götalandsregionen
Alingsås närhet till Göteborg gör att du på ett snabbt sätt tar dig hit med tåg, buss eller bil."

REGIONAL ROLE

"Alingsås lasarett byggdes redan 1910 och har under åren både byggts om och byggts till.
Men då som nu, är det ett litet och idylliskt sjukhus i en naturskön miljö, nära till såväl
centrum som till sjön Mjörn och vackra rekreationsområden."

TRADITION
"Närlighet, öppenhet, dialog och trygghet är viktiga ord på Alingsås lasarett. Vi är bra på närsjukvården, vi har bredden och fokuserar på helheten."

CLOSENESS; PERSONAL CARE; GENERALIST CARE
"Utifrån detta har vi byggt upp ett väl fungerande sjukhus som omfattar såväl öppen som sluten vård."

EFFECTIVENESS
"Vi värnar om kontakterna med samhället och söker gemensamma lösningar med primärvården och kommunen. Alingsås lasarett är i ständig utveckling."

CONSTANT IMPROVEMENT; HEALTH SYSTEM PARTICIPATION
"Samhället förändras, nya behandlingsmetoder och ny teknik ställer nya krav och vi har gott om idéer för att följa med i denna utveckling."

CONSTANT IMPROVEMENT; MODERNITY
"Medarbetarnas engagemang är en stor tillgång i detta arbete."

COMMITMENT
"Vi har välutbildade och specialiserade medarbetare som arbetar i vårdlag."

COMPETENCE; EXPERIENCE
"Här arbetar drygt 600 personer och det finns cirka 100 vårdplatser."

Upptagningsområdet omfattar 90000 invånare och vi har cirka 50000 besök per år. Av dessa är 15000 akuta besök. Varje år görs 32000 röntgenundersökningar.

QUANTIFICATION
"Värdegrund, vision och verksamhetsidé"

BUSINESS CONCEPTS
"Delärsrapport och årsredovisning."

REPORTING

12/2/13

"Välkommen till Alingsås lasarett
På Alingsås lasarett erbjuder vi dig god vård dygnet runt. Vi är ett hälsofrämjande sjukhus
som arbetar för att främja din hälsa."

WELCOMENESS; ACCESSIBILITY
"Vi vill ge dig som patient:
God vård
Hög tillgänglighet
Trygghet, omtanke & kompetens."

ACCESSIBILITY; TRUST; EMPATHY; COMPETENCE
"Närlighet, öppenhet, dialog och trygghet är viktiga ord på Alingsås lasarett- Vi är bra på närsjukvården, vi har bredden och fokuserar på helheten."

CLOSENESS; PERSONAL CARE; GENERALIST CARE
"Öppet dygnet runt
Tillgängligheten är hög med service 24 timmar om dygnet, året runt. Akuta undersökningar utförs samma dag."

ACCESSIBILITY
"Främjar hälsa
Sjukhuset är ett hälsofrämjande sjukhus. Detta innebär att sjukhuset arbetar aktivt för att hjälpa patienter, personal och befolkningen in närområdet att uppnå en mer hälsofrämjande livsstil. Sjukhuset är rökfritt sedan flera år."

NO SMOKING POLICY
"Samverkar med omgivande samhälle
Sjukhuset samverkar med kommuner och primärvård i närområdet med inriktning att ha en gemensam helhetssyn för patientens väg genom vården."

HEALTH SYSTEM PARTICIPATION
"I siffror…
På sjukhuset arbetar drygt 650 personer och det finns cirka 100 vårdplatser.
Upptagningsområdet omfattar 100000 invånare och vi har cirka 50000 besök per år. Av dessa är 25000 akuta besök."

QUANTIFICATION
"Vision, värdegrund och verksamhetsidé."

BUSINESS CONCEPTS