

Managerial aspects on governance of healthcare in Iceland

Guðjón S. Brjánsson

Master of Public Health

MPH 2014:42



norden

Nordic School of Public Health
NHV

Managerial aspects on governance of healthcare in Iceland

© Nordic School of Public Health NHV

ISSN 1104-5701

ISBN 978-91-982282-7-4



Master of Public Health

– Thesis –

Title and subtitle of the thesis				
<i>Managerial aspects on governance of healthcare in Iceland</i>				
Author Guðjón S. Brjánsson				
Author's position and address Manager of V-Iceland Healthcare Institution Laugarbraut 15 300 Akranes Iceland				
Date of approval 09.12.2014		Supervisor NHV/External Helga Sól Ólafsdóttir, DrPH		
No. of pages 58	Language – thesis English	Language – abstract English	ISSN-no 1104-5701	ISBN-no 978-91-982282-7-4

Abstract

Purpose: This study aims to analyze managerial aspects of governance within Icelandic healthcare institutions, particularly regarding job descriptions and policy-making plans.

Method: We used a qualitative research method and content analysis to examine data collected from semi-structured interviews Ten participants (5 males and 5 females) who worked as senior managers, middle-management executives in the healthcare service, and Ministry of Welfare officials. The participants reflected a breadth of experience and education across the spectrum of age, length of service, and work experience in both hospitals and primary care.

Results: Data analysis revealed three main categories including *policy-making plans in health care*, which identified a considerable gap between managers and executives on one side and the Ministry of Welfare on the other, especially regarding strategy. Incidental control and effect of politicians on healthcare operation. Second, in relation to the Ministry of Welfare and healthcare institutions we observed unstructured, onerous, and remote *communications and organization* that focused too little on professional issues. The Ministry of Welfare tended to interfere with managers' responsibilities and scope of work. Third, we observed *strengths and weaknesses in management*. Strengths included administrators' enthusiasm, ideas of empowerment, short lines of communications, and often straightforward interactions, compared with *weaknesses* in the work processes within healthcare institutions and toward the Ministry of Welfare, and also in job descriptions and vague definitions of the institutions' role.

Conclusion: The indications reported here suggest unclear policy-making plans for healthcare institutions. Although managers and executives maintained that visions for the future are vague, the Ministry of Welfare stated that the strategy was clear. The study identified a need of strengthening and restructuring the way of communications, as well as clarifying managers' role toward the Ministry of Welfare

Key words

communication, governance, healthcare management, health policy, leadership

CONTENTS

1 INTRODUCTION	5
2 BACKGROUND	6
2.1 Public health	6
2.2 The Nordic countries	7
2.3 An overview of the Icelandic healthcare system	8
2.4 New emphases in Iceland	10
2.5 The performances of healthcare institutions	12
3 THEORETICAL FRAMEWORK	14
3.1 Defining management	14
3.2 The role of manager	15
3.3 Managing healthcare institutions	19
4 THE AIM OF THE PROJECT	22
4.1 Objectives	22
4.2 Aim	23
5 METHODOLOGY	24
5.1 Method	24
5.2 Design	24
5.3 Participants	24
5.4 Data collection	25
5.5 The author's role and position	26
5.6 Analysis	26
5.7 Ethical considerations	27
5.8 Reliability and validity	28
6 RESULTS	30
6.1 <i>Policy making in healthcare</i>	30
6.1.1 Pledged policies and their manifestation	30
6.1.2 Politics and budget	31
6.1.3 A manager's role and position	34
6.2 <i>Communications and organisation</i>	34
6.2.1 Managers' experiences	35
6.2.2 Working relationship with the Ministry	35
6.3 <i>Strengths and weaknesses</i>	37
6.3.1 Work processes within the institutions	37
6.3.2 Community support	38
6.3.3 Definitions and responsibilities	39
6.3.4 Empowerment	40
7 DISCUSSION	42
7.1 Result discussion	42
7.2 Method discussion	46
8 CONCLUSION AND REFLECTION	48
9 ACKNOWLEDGEMENTS	49
10 REFERENCES	50
APPENDIX 1: Information about the study	56
APPENDIX 2: Interview frame	57

1. INTRODUCTION

Through the decades and to this day, hospitals and healthcare institutions have been among the central institutions of each society. However, they may also be controversial institutions at times, especially for administrative and operational reasons, as well as due to administrative or communal trends (Axelsson, 1998). In the past few decades, these types of issues have raised considerable public debate and led to a number of reports and reforms (Andersen and Jensen, 2010, Axelsson, 2000, Halldórsson, 2003, Oppedal and Stigen, 2005).

The author, as a manager of a healthcare institution, is basing this study on his personal experience of the Icelandic healthcare system. Through the years, policy makers and even the general public have from time to time wondered and debated whether managers of healthcare institutions perform their tasks effectively and whether management practices and focus of work are in accordance with job descriptions, responsibilities and expectations. Management and leadership styles of individual managers have also been under discussion.

Inspired by this debate and aware of the major structural changes and management of healthcare in the other Nordic countries, this study is focused on the circumstances in Iceland.

2. BACKGROUND

In the wake of the industrial revolution in the late 18th century, great social changes were felt throughout a number of countries. Alongside the growth in population, urbanisation increased and practises altered with mechanisation and factory operations. Furthermore, with the gradual increase in educational opportunities, scientific knowledge also increased. This increase was both in health education as well as other areas of professional education, and as a result, healthcare progressively improved. As can be expected, this social development coordinated with the economy, customs, attitudes, and traditions of any given place. Today's nations, as scholars have pointed out, may still live with unequal quality in healthcare which can be traced back to each nation's history, culture and governance. Thus, healthcare and institutional structuring has taken place in various forms and in accordance with those social contracts that governments and their respective citizens have formed (Lameire, Joffe and Wiedemann, 1999).

2.1 Public health

Through time, emphases in healthcare have shifted considerably. Instead of a specialisation in care and the curing of diseases there has been a shift towards two other aspects, namely health promotion and health prevention. Additionally, there has been increased awareness and use of rehabilitation for those dealing with the after effects of accidents, diseases and trauma (WHO, 2004b, WHO, 2007).

Health prevention revolves around preventative actions such as reducing diseases, injuries, social problems, premature death and environmental risk factors. However, health promotion centres on improving the quality of life, health and wellness, as well as assisting people to correctly respond to the pressures and demands of everyday life (Einarsson, 1995).

The above is in accordance with the way The World Health Organisation (WHO) understands the concept of public health. The organisation also comprises the concept of the maintenance and improvement of health, wellness and circumstance of nations and social groups. This is done through health protection, healthcare, health promotion, research and social responsibility, and is constructed out of cooperation in society and interdisciplinary partnership (Ministry of Health and Social Security, 2008, WHO, 2009).

The first international conference on health promotion was held in Ottawa in 1986 and was an answer to the call of a new international movement focusing on public health. At this initial conference, members mainly looked towards the industrialised areas of the world, though not overlooking other areas. Since then, on WHO's behalf, more international conferences on the subject have taken place worldwide and furthermore, there seems to be increased importance in nations' reporting on this particular aspect of health (WHO, 2009).

In September 2012, WHO's European Offices approved a healthcare policy that should be in effect until 2020 (Health 2020). Its goal is to create a harmonised outline for the policy making in healthcare in Europe, which tackles the main health issues of member states. Furthermore, the measures described in the policy are based on evidence-based and effective processes (WHO, 2012).

In fact, the implementation of public health objectives takes place ubiquitously in our surroundings. For instance, authorities in Iceland organise them in various ways but the key initiatives are found in public institutions such as primary healthcare facilities. Hospitals and other healthcare institutions also work diligently towards opening dialogue and coverage of public health objectives. They also try to reduce interceptive actions, prevent hospitalisation, and encourage and educate professionals and their clients on the importance of healthy living (Ministry of Health and Social Security, 2008).

2.2 The Nordic countries

Currently the five Nordic countries are now independent states; however, this has not always been the case. These countries have in the last thousand years had close political relations, been partially united and in a constitutional community. To this day, they are considered alike in aspects and practices. Sometimes this is referred to as a Nordic social structure or the "Nordic model".

Kristiansen and Pedersen (2000) have compared healthcare in the Nordic countries. According to their comparison there are a number of common aspects. These are the principles of equality, of equal access to healthcare, of affordable service charges and the notion that the government funds the largest part of the healthcare operations and finances hospitals. In these countries there is a similar level of education in the healthcare services and good access to doctors and medical professionals. However, according to their finding there is a difference in arrangement on various levels. Thus, in Denmark there is an emphasis on primary care, which differs from what takes place in Sweden. Healthcare services in Finland have moved towards privatisation and capitalism, thereby creating some distinctiveness among the Nordic countries. There is also a difference in these nations' consumption of healthcare services, as well as a difference in their definition of service need. The staffing of doctors is presumed to be similar, even if Norway considers itself in need. Additionally, Iceland has some distinctiveness in these comparisons, mainly though in light of their small population and for being as the most centralized in this aspect among the Nordic countries (Kristiansen and Pedersen, 2000).

Examination of institutional environment in healthcare in the Nordic countries clearly shows that vast changes have been taking place in these past decades. Runo Axelsson (2000) has investigated the evolution in hospital services in Sweden between 1865 and 1998 and the changes that have followed. He believes that while similar changes have taken place in other countries, Sweden sets itself apart by the magnitude and frequency. In his study Axelsson divides the period into five distinct evolutionary phases. They begin with the definition of the traditional institution around 1865 and conclude with the

phase of quality management around 1996. It is characteristic of these phases that they continually became shorter and therefore the changes in healthcare became ever more frequent. Now, this can possibly be explained by recurrent attitude changes in society and also by elements of what is in fashion in the area of management. However, Axelsson warns that the speed of the frequency of changes can still grow. As a result there will be fewer opportunities to independently assess current operations and learn from past experience. In these circumstances it is good to rely on resources such as a more focused administration and an increasing reliance on systematic, empirical and evidence-based solutions. Axelsson (2000) terms this as an evidence-based approach or as evidence-based management.

Several of the Nordic healthcare reforms since the early 1990's have had at least one characteristic feature. That is the wish to minimise politics in the decision-making process. This represents a new way of rethinking hospitals that is strongly influenced by the private sector and industry. This development has been comparable to the market-orientated reform wave known as „new public management“(NPM) (Hood, 1995; Savoie, 2003). NPM emphasises the need to rethink how the public sector is organised and managed. The day-to-day operations should be performed without intervention from politicians. These reforms intend for politicians to be occupied with ideological and strategic questions and leave the implementation and details to professional managers. While the reform elements have been designed differently in the Nordic countries, many similarities such as regarding the changing roles of patients and budgetary efficiency remain key focus areas (Kjekshus, 2009; Martinussen and Magnussen, 2009).

2.3 An overview of the Icelandic healthcare system

Iceland is the world's 18th largest island, and Europe's second largest island after Great Britain. The entire country is 103,000 km² in area, and with roughly 325,000 inhabitants in 2014. It is also the most sparsely populated country in Europe, averaging around 3.1 inhabitants per km². Furthermore, about 200,000 of the country's inhabitants live in and around the capital of Reykjavik on the southwest coast.

The Icelandic healthcare system has primarily been structured around the notion of diagnosing and treating diseases. However, in the spirit of modern thinking the government has placed increasingly more emphasis on healthy living and people's responsibility in their own health. (Ministry of Health and Social Security, 2008; WHO, 2009).

The current healthcare policy in Iceland was formulated in 2008 and was in effect until 2011. In the spring of year 2012, a new healthcare plan was begun and a draft is here already but it has yet to be approved. A renewed healthcare plan reflects international emphases and simultaneously rests on the foundation of former national plans and current laws. The plan also refers to the healthcare policy of WHO (Health 2020), both in terms of emphases and the period of validity. This new plan would evaluate possible direct or indirect effects of certain actions, laws, regulations, drafts, and other governmental measures on public health as there is already considerable knowledge of

how environmental and organisational aspects can affect the development of diseases and other health problems (Ministry of Welfare, 2012).

The Act on healthcare service no. 40/2007 forms the basis of the Icelandic healthcare services. According to this law, the Ministry of Welfare governs the organisation, approach and funding of the healthcare services in the country. The Ministry also executes the government's plans regarding healthcare and social services. According to laws, regulatory acts, and terms of reference, the Minister of Welfare is responsible to the government and the Parliament, while the managers of healthcare facilities are responsible to the Minister.

The Ministry of Welfare is responsible for citizens having access to healthcare services, receiving support, help and treatment against diseases and accidents. Additionally, the Ministry is responsible for a number of other things such as the efficiency and quality criteria within the healthcare system, staffing, housing, medical equipment in their facilities and medical transport services (Ministry of Health and Social Security, 2007a) This Ministry was re-formed and re-named on January 1st 2011 as the Ministry of Welfare and has since then the responsibility for administration and policy making of as well as social affairs, health and social security.

There are 75 municipalities in the country and they are further split into seven healthcare regions. The role of the regions is supposed to organise, strengthen and improve the local healthcare service, as well as to ensure that every citizen, as far as it is possible, has equal access to the service (Ministry of Health and Social Security, 2007a). While government policy is that each region has one hospital, that goal has just partly been realised. Additionally, while the municipalities are generally not responsible for healthcare services they mostly take care of the social services, such as elderly care, domestic services and manage affairs of the disabled.

There are two acute hospitals in the country situated in Reykjavík and Akureyri, and six smaller regional hospitals that work in conjunction with primary care facilities. Additionally, there are 10 other healthcare facilities around the country that offer both primary care and medical services, such as home nursing, school healthcare, maternity care and child healthcare. Moreover, there are 23 clinics in rural areas that offer service day and night.

The regional hospitals offer various levels of specialist care but the government's policy is, that specialist care should move away from the smaller hospitals towards the larger institutions. In Iceland there is also a number of private practitioners providing specialist outpatient care. These may either be working on their own or providing service through group practice. They work on a fee-for-service basis, with most of them situated in Reykjavík. The private practitioners are the most rapidly growing part of the healthcare sector in volume. Aside from these practitioners and a few other exceptions, the primary care and healthcare institutions in the country are publicly owned. Unlike in most developed nations, there are no private hospitals in Iceland, and private insurance is practically non-existent. The citizens of Iceland have the freedom to choose their healthcare provider and there is no gatekeeping system to the services of privately operating specialists.

About 80% of the operational expenses of the healthcare services are paid for by taxes and executing these services is mostly state supervised. However, the operation of elderly care facilities is mostly in the hands of municipalities, private owners and charitable organisations.

The government's policy in Iceland aims to reduce direct and indirect expenses due to diseases and accidents by emphasising health prevention and strengthening primary care. By strengthening this aspect, they hope to create better general access to healthcare and enforce the policy that primary care facilities are the first stop for people that need healthcare. However, Iceland still differs from other Nordic countries in the sense that lower importance is placed on public health policy as opposed to curative measures. While much emphasis on prevention and communal health is common to the other Nordic systems, Iceland does not share this emphasis to quite the same extent yet (Ásgeirsdóttir, 2009).

Current laws regarding healthcare services explain in generalities the role of the manager of a healthcare institution in this way: *"The Chief executive is responsible for the facility he/she manages, that it operates in accordance with law, government directives, and the terms of reference under paragraph 3. The Chief executive is responsible for the service provided by the facility, for operating expenditure and performance of the facility being in accord with the Budget, and for effective use of funding"* (Ministry of Health and Social Security, 2007a).

As referred to in the above paragraph, all managers of healthcare institutions receive terms of reference when they are hired. In article 3 of that paper, the manager's main duties are listed as follows:

- Craft an organisational chart for the institution
- Craft a yearly work- and budget forecast
- Work towards a long term policy direction
- Run the day-to-day operations, hire staff and oversee personnel
- Work towards innovation and changes in the operational activity to further benefit patients
- Promote the development of, and review of the institution's performance
- Work towards the harmonisation of all aspects of the service
- Work towards the objective that the institution can meet the demands of educational institutions regarding the teaching and training of medical students
- Strengthen the collaboration with other healthcare institutions, hospitals and primary care facilities
- Complete other tasks set by the healthcare services authorities (Ministry of Health and Social Security, 2005).

2.4 New emphases in Iceland

Many of the substantial changes of health systems in recent decades that have been implemented in various parts of the industrialised world, such as in the Nordic countries, have been outlined under the term of New Public Management (NPM) (Hood, 1995; Savoie, 2003). Some Icelandic policy-makers have looked with interest toward these changes in the Nordic countries. These are changes such as, for example,

those that allow for market forces to have a greater role and for the utilisation of economic incentives for healthcare providers. The organisational structures of the Icelandic system have in fact undergone some formal changes to improve its handling of a more market-oriented system. Consequently, the Icelandic Health Insurance was set up in 2008 to achieve an increased purchaser-provider split by acting as the government's purchaser of healthcare services. Nevertheless, legal provisions on this point have been repeatedly postponed and have only come into effect to a limited extent. The relative role of the private sector in healthcare is still substantially smaller in Iceland than in the other Nordic countries (Ásgeirsdóttir, 2009).

It was in the mid-nineties that revisions and altered methodologies were introduced in the management of governmental agencies in Iceland. Consequently, the work environment of civil servants changed. This policy was introduced in a publication titled *A Policy on innovations in governmental operations* (Ministry of Finance and Economic Affairs, 1996a) under the slogan *simplification, responsibility and success*. The publication was built off the ideology of New Public Management (NPM). The goal of the changes in the work- and operations environment was to make the state more able to fulfil its obligations towards society economically, efficiently and successfully.

In 1996, to make sure that the aforementioned objectives were achieved, the law was changed. This change increased the independence and flexibility of public offices as regards staffing. The law shifted the decisions and responsibility for management and staffing over to the public offices (Ministry of Finance and Economic Affairs, 1996b). This change in the government staffing policies was believed to be the prerequisite for a more efficient and economical state operation.

The policy making role of the minister, as well as his authority to implement these policies, were further reinforced with a change in the law in 2003. Additionally, the changes in law removed the board of executives in healthcare institutions and hospitals.

Then in 2007, even newer healthcare service laws were passed to replace old laws from 1990. The main objective of these new laws was firstly, to further clarify the basic organisation of the public healthcare services. Secondly, to provide a legal framework to follow for the Minister of Health, as well as for the healthcare services authorities, and particular healthcare institutions. Thirdly, to ensure effective supervision over the quality and performance of the healthcare services. Lastly, to further define the policy making role of the Minister of Health within the law, and to ensure he has the appropriate legal authority to enforce his policies. The policies could, for example revolve around the organisation of the healthcare service, the prioritising of assignments within it, and where the healthcare service should be provided and by whom (Ministry of Health and Social Security, 2007a).

The shift of emphasis inherent in these new laws increased the demands on employees and management of healthcare institutions, as well as that of other public institutions (Aðalsteinsson, 2010). For example, there was a provision on managers implementing modern management ideas, and being positive and collaborative with employees. Managers were also to closely observe their employees, guide them when necessary and

ensure their increased development and growth. Therefore, to achieve these operational objectives it was practically assumed that the public sector turned towards the management methods utilized in the private sector in the spirit of New Public Management principles (Aðalsteinsson, 2010).

Still, as other Nordic countries, Iceland has recently implemented what at the outset seems to be a decentralisation of the health care system. This has been done by dividing the country into seven healthcare regions, as earlier described. This has been done not to necessarily devolve power to the regions. In fact, the creation of healthcare regions was largely motivated by the need to increase mergers and cooperation between institutions. Such institutional mergers have been taking place systematically since the mid 1990s and are still taking place both in Iceland and other Nordic countries.

2.5 The performance of healthcare institutions

In the autumn of 2007, an extensive survey of the work environment of around 200 public officials in Iceland was presented. This survey gathered information about managers' attitudes towards a number of aspects of their work environment. This included, for instance, their anonymous evaluation of communications with their respective ministry. The survey found that less than a half of the managers were content with communications with their Ministry. Furthermore, only one out of ten believed that the Ministry promptly responded to queries and gave helpful feedback on their work. When it came to communications regarding specific matters, policy making or performance management, the most negative responses came from managers of healthcare institutions. The survey questioned the financial and professional freedom of managers, and again the lowest contentment scores came in the category of managers of healthcare institutions. However, the large survey found that managers of healthcare institutions were most positive in their attitude towards the Ministry's distribution of information and consultancy, apart from elements relating to financial facilities (Kristmundsson, 2007).

It is important to remember that the Icelandic healthcare system is more centralised in governance structure, management, regulation, implementation and financing than it is in the other Nordic countries. The Minister of health oversees practically all health affairs while the involvement of local authorities in financing is limited to exceptional instances. For the most part, institutions are financed by a fixed yearly budget.

The Icelandic National Audit Office (INAO), as an independent monitoring body of Althingi, has for a number of years made annotations on public institutions in Iceland. Those annotations regard the lack of control in management, including the management of healthcare institutions. The INAO sends reports and reviews to Althingi, the Icelandic Parliament, and it was as recently as 1996 that they performed an administration audit of seven hospitals outside the capital. The audit, for example, stated that in the preceding years, deficits from operation of hospitals were a rule rather than an exception. They further stated that even if ineffective management and insufficient financial restraint can partly be blamed for the hospitals' budget deficits, they are not

enough to explain the entire deficits from operation (The Icelandic National Audit Office (INAO), 1996).

Since then and until present time, the INAO has repeatedly covered these issues and frequently reiterated these points of view to the authorities. In a report from 2008 it is emphasised that the INAO has pointed out a number of things that have not been addressed, such as defects in the implementation of the general budget, a lack of respect in its execution, and a general lack of discipline from a number of institutions. The INAO also finds that the repeated refractions of the finance laws and regulations regarding budget execution, as well as the Ministry's inactivity in reacting to this, shows that the responsibility does not entirely lie with the managers of institutions (INAO, 2008).

For further illustration, the INAO, still in a report from 2012, points out that seven out of eleven healthcare institutions have deficits from operation. Furthermore, four out of the seven utilise a bank overdraft to uphold their day to day operations. A report from 2013 further states that nine out of eleven rural healthcare institutions have deficits of operation. Moreover, the report states that this is illegal and challenges the Ministry to find a responsible solution to the institutions' dilemma (INAO, 2012, 2013).

There are definite law- and regulatory provisions that are in effect for the execution of the general budget (INAO, 2012, 2013). These provisions provide the Ministry with legal recourses to establish a disciplined budget management within institutions that have financial difficulties for years on end. However, managers of healthcare institutions in Iceland generally leave their positions on their own initiative or during the dismantling or merging of institutions. Regardless of deficient operational success and reiterated annotations from the INAO, the Ministry has not utilised any of the legal recourses within their purview.

In this regard it is not easy to compare the circumstances of managers of healthcare institutions across the Nordic countries. Most places have experienced tumultuous organisational adjustments as the healthcare service has undergone systematic and administrative changes. Furthermore, institutions have merged or been closed, which has generally led to fewer managers. Kjekshus (2009) has pointed out that much more research is needed to be able to verify the impact of those changes in recent years. However, judging from media coverage in other Nordic countries, the hints are that managers hold their positions for a shorter time due to initiative from government or authorities. Yet, examples from Sweden and Norway show that insufficient operational results or a breakdown in communication often seems stated as the main reason for action taken (Websites, examples of media coverage, accessed August 2014).

3. THEORETICAL FRAMEWORK

3.1 Defining management

The line between a manager and a leader may often seem unclear. However, Stephen R. Covey (1996), in the book *The Leader of the Future*, maintains that there is a significant difference between management and leadership. Both are vital functions and because they are, it is critical to understand how they are different so one is not mistaken for the other. Covey further states that leadership focuses on doing the right things, while management focuses on doing things right. If using his metaphor, leadership makes sure that the ladders for climbing are leaning against the right wall, while management makes sure that ladders are climbed in the most efficient way possible (Covey, 1996).

Daft and Marcic (2001) have also discussed the distinction between the terms “management” and “leadership”. According to their definition there is a substantial and important difference between the two. They argue that the management power comes from the organisational system, it encourages stability, order and problem solving within the structure. Leadership on the other hand has its origin around personal sources that are not invested in the organisation in a similar manner which is in terms of personal interests, goals and values. Essential difference between the manager and the leader therefore relates to how the power and influence is obtained and the level of compliance this generates among supporters (Daft and Marcic, 2001). Hence, management has the overtones of carrying out objectives laid down by someone else, as John Adair points out. There is nothing in the concept of management which implies inspiration, creating teamwork when it is not there, or setting an example. When inspiration and teamwork exist, you may well have managers who are in effect leaders, especially if they are the source of the inspiration (Adair, 2004).

Certainly many definitions of the terms ‘management’ and ‘leadership’ have been introduced. These terms are frequently used nowadays and the difference between them widely debated. However, Henry Mintzberg believes that the difference between these terms is in fact irrelevant and points out in his book *Managing* that “Leadership cannot simply delegate management; instead of distinguishing managers from leaders, we should be seeing managers as leaders, and leadership as management practiced well” (Mintzberg, 2009, p. 9).

Furthermore, scholars have not yet agreed if management comes entirely from talent, attributes or heritable behaviour. Initially, the theory was that the attributes of effective managers were heredity, or some type of gift that could not be learned. However, scholars later pointed out that by increasing their knowledge, everyone has the possibility of becoming a good manager (Axelsson, 1998, Baker, 2003, Daft and Marcic, 2001, Mintzberg, 2009).

The term management is after all fairly broad and serviceable in a wide array of circumstances. The formal definitions thereof tend to be shaped by the context in which the term is being used.

WHO defines the term management differently, depending on the context. The definition used here is found in the WHO publication from 2004, called *Management, Leadership and Partnership for District Health*. It states that management is: “An organized process that guides the utilization of various resources – human, financial and material – to meet a desired organisational goal taking into consideration consumers’ demands (clients’ needs), and the political and economic situation” (WHO, 2004a, p. 1).

In the book *Healthcare Management* the term itself is not defined but the term ‘management work’ is defined shortly as “Decision making about the organisational context within which work is performed” (Shortell and Kaluzny, 2006, p. 535).

When the term management is used in context with the hospital environment it is good to look towards Schultz and Johnson’s definition of hospital management as “the coordination of all resources through the process of planning, organizing, leading and controlling in order to obtain stated objectives” (Schultz and Johnson, 1983, p. 14).

3.2 The role of manager

Many scientists and scholars have reported on management and organisations. While the author has a great respect for all contributions towards the increased understanding of the subject matter, he limits his theoretical summary to the take of a very few respected scholars in this area. These scholars have enjoyed, and still enjoy, international attention and recognition for their research, writing and theoretical work on the subject.

A manager’s role and work scope is generally complex. Currently there is increased demand for managers having a comprehensive practical knowledge, training and managerial competence. As institutions expand, take on more wide-ranging projects and expectation of more advanced planning increases, so too will demand for specialised education (Axelsson, 1998).

A number of scholars have covered the aspects regarding the role of the manager. Kreitner (2006) and Northouse (2004), for example, define the role of the manager as mainly revolving around, working with (cooperation) and through (management) others to achieve the set objectives of the organisation. However, Henry Mintzberg (2009) defines the roles of the manager as being the responsible person for the institution or a defined unit thereof.

According to Sayles and Strauss (1966), managers are among those employees that have a special interest in the mechanism, efficiency and effective methods of the organisation. Individuals with management- or leadership abilities can be found far and wide in the institutions and not all of them occupy defined management positions. Instead they are, as he calls them, informal leaders (Sayles and Strauss, 1966). Those people might make suitable management material and often seek out added responsibility by taking on projects.

When discussing these theories, one of the most commonly asked questions is: “Is the work of managers best described by the objectives of management or the roles one

undertakes as a manager?” This question was posed in 1971, when Henry Mintzberg established his contemporary theory on Management roles, which differed from Henri Fayol’s 1949 classical theory on Management Functions (Mintzberg, 1975, Wren and Bedeian, 2009).

Henri Fayol is thought of as a pioneer in the field of management science, and among the first scholars that defined management as a discipline. His theory about management and administration was built on personal observation and experience of what worked well in terms of organisation. In his time, Fayol clarified the versatile roles of managers, the elements of management. Over the years Fayol’s original list of managerial functions has been updated and expanded by management scholars. Those clarifications are to a certain extent still relevant to the roles and actions of the modern day manager (Wren and Bedeian, 2009).

Fayol argued that certain principles existed which all organizations must follow in order to operate and be administered efficiently. This type of assertion typifies a “one best way” approach to management thinking. Firstly, the role of planning, the starting point which creates a framework for future decisions and involves the course and vision of the organisation, as well as how it can be achieved. Secondly, the organisational role, which involves designing roles, delegating tasks between roles and outlining the work allocation. Thirdly, the leadership role, which comprises of encouraging employees and ensuring that everyone is working as a united whole towards a common goal. The fourth matter is the role of supervising, which comprises of issuing directions, making sure they are followed and goals are achieved. Lastly in Fayol’s opinion, the role of managers was to maintain control to ensure that these core objectives were met, and also to steer employees back to the correct path if they had deviated from set objectives (Wren and Bedeian, 2009).

Henry Mintzberg articulated Fayol’s fundamental belief that management is about applying human skills to systems, not applying systems to people. On the other hand he argued that Fayol’s principles of management did not embody the turbulent nature of managerial work. He conducted empirical research, which involved observing (“structured observations”) and analysing real activities of managers from private and semi-public organizations and noted several flaws from Fayol’s management functions. He maintains that, in spite of multiple theories and models of management, the behaviours and roles of the best managers clash with the academic definition of their role. Additionally, that this is due to the fact that managers are continually responding to unforeseen external influences, are governed by circumstances and often have to make sudden decisions without any notice (Mintzberg, 1993, 2009).

Mintzberg has written substantially about the managerial roles. On the basis of his research, he divides the role of a manager into three main subjects, under which fall ten functions. Firstly, there is the subject of communication. Under that fall the functions of being a spokesperson, of having the operational responsibility for the organisation and its employers, and of motivating and guiding the employers. It also encompassed the function of being a liaison within departments and units in the organisation and from it to the outside community. Lastly, under this subject falls the very important function of

being a leader, which the fulfilment of often serves as a judgement of, if a manager's efforts have failed or succeeded. Secondly, there is the subject of information distribution. The managerial functions that fall under that subject are being a reception executive, which accepts and processes information within the courses of action available to him. Next, to act as a "neural" net of information distribution, which distributes internal and external information to the organisation. Additionally, there is the function of a group spokesman, which is done in the name of the stakeholders of the organisation. Thirdly, there is the subject of decision making. According to Mintzberg, the functions that fall under this subject are those of influencing and initiating change, and mediating and steering under unexpected circumstances or in conflict. Then there is the function of distributing resources that are important for the operation, such as capital (Mintzberg, 1975).

According to Peter Drucker, Fayol's functional principle leaves little scope for innovation and is thus inadequate when working to develop, test and prepare employees (Drucker 1982). Throughout his career, Drucker has devoted considerable effort and space to define the nature and role of management. In 1954 he proposed the theory of management by objectives (MBO), which is still used in businesses and organizations today. This theory centres on businesses and organisations deciding upon organisational objectives. These objectives are broken down into departmental objectives and then down into individual employee objectives. Moreover, as employees are involved in this process, Drucker suggested that motivation will improve, as explained below.

Drucker argues that leadership is valuable; it gives the organisation meaning, defines and nurtures its central values, creates a sense of mission, and builds the systems and processes that lead to successful performance. Drucker points out that the role and competence of managers lie in five aspects, with the first being goal setting. In goal setting the managers set goals and the means to achieve them and then impart this to employees so that they work towards these goals. The second aspect involves organisation, where the manager analyses the operation, defines the roles and tasks inherent in the operation, and hires necessary staff. The third aspect is the motivation, where the manager has to build a strong team, attract talented staff, as well as retain, train, develop and ensure the continued growth of this staff. The fourth aspect of the manager's role has to do with performance and feedback. This is in the sense of being able to objectively measure staff performance through, for example, a performance evaluation system or staff interviews. Finally, the fifth aspect revolves around the growth and development of the individual, where the manager himself grows and thereby influences growth in others (Drucker, 1974).

More academics have introduced theories that propose increased emphasis on participation and involvement of employees in shaping the work environment when focusing on changes. The Transformational Leadership Theory (TLT) is among those. This theory was initially presented in 1978 by James MacGregor Burns. He was one of the first to study leadership as a relationship between leaders and followers rather than simply as an assessment of the traits that set leaders apart (Goethals and Sorenson, 2004). Burns' work and theory has later been extended by Bernard M. Bass. The

fundamentals of these theories are terms such as connection, leadership, environment, and that operational changes take place with an active support and participation of staff. In this type of process, the objectives of success that are being aimed at are likely to be reached (Bass, 1990).

However, Gary Yukl (1999) has evaluated the transformational and charismatic theories. He finds that there is considerable evidence that transformational leadership is effective but he has also identified some conceptual weaknesses. Yukl maintains that unlike the most “traditional” leadership theories, which emphasise rational processes, theories of transformational and charismatic leadership emphasise emotions and values and include more individualised consideration. Even though leadership is viewed as a key determinant of organisational effectiveness, these processes receive insufficient attention in most theories of transformational leadership. They do not, for example, describe the underlying influence processes clearly, nor do they specify how the leader behaviors are related to these processes. Therefore, some serious conceptual weaknesses need to be corrected to make the theories more useful. Yukl further argues that no single theory should be expected to include all aspects of leadership behavior and he questions some of the assertions from Bass (1990) about the completeness of these as full-range leadership theory.

Yet another option to approach is strategic management. Those principles have much in common with MBO and incorporate many theories and methods from companies, public institutions, or other organisations. Examples are planning and clear formulation of objectives, extensive training and participation of employees and progress monitoring (Bass, 1990). Strategic management is a composite term for a field that is most commonly known as policy making, policy making planning, or even effective management. This concept has evolved over time and another notable approach for policy implementation has emerged. In this strategy, a policy is considered as a process and a pattern of acts and has been called *a strategy as an emergent phenomenon* (Steinþórsson, 2003b). The starting point of this strategy is for the policy to be created with employers, clients and other interested parties collaborating and communicating with each other. Moreover, it is assumed that the work inherent in the planning, shaping, and execution of the policy is intertwined, and therefore not easily torn apart (Steinþórsson, 2003a).

Many scholars therefore, including Edgar J. Meyer (2008) have stressed how important it is to communicate the strategy clearly towards all the respective team members. If people in the organisation do not know or understand the strategy, they have no way of using it as a basis for their decisions or actions. When strategy is determined by only a few of the top people in the organisation, the risk becomes that employees have little, if any, ownership or belief in the chosen strategy (Meyer and Slechta, 2008).

Paul Strebel also points out that for many employees, including middle managers, the fact is that change is neither sought after nor welcomed. Furthermore, change can be felt as disruptive and intrusive, and may upset the balance. According to him, these views are often underestimated (Strebel, 1996).

Mintzberg and Gosling (2002) approach the subject of managers' role both theoretically and practically. They focus on the actual environments and emphasise that in order to be a good manager, one has to at least possess the following qualities:

Firstly, there is the ability of self-control. Here it refers to a person's awareness of his/her feelings and actions. Additionally, it is essential that a manager can handle events which are taking or have taken place in his or her personal life. Individuals with a strong identity generally have a good self-esteem, are even-tempered, positive, and do not let irritations influence them.

Secondly, there is the ability to manage relationships. This refers to the ability to cooperate with others. Individuals with this ability are usually radiant social creatures with a good self-control and a comfortable presence. This ability also requires focus and self-discipline to empathise with others. An important part of this is also to understand the expectations of others and align those with your own conduct and behaviour.

Thirdly, there is the ability to control the operations of a company or institution. In running an institution or a company it is important to possess the ability to correctly read your environment and make realistic decisions. Also there are a number of things that can influence and skew decision making, such as an excess of self-esteem, optimism, pre-supposition or personal experience, as well as a flaws in a person's reasoning.

Next, there is the ability to understand and handle the cultural context. This aspect refers to the development of managers in an international setting. These factors call for mobility, travel and the experience of another country's culture. Therefore, with increased globalisation managers need employees with international knowledge and background.

Finally, there is the ability to control changes in the environment. Work-place and environmental changes are an inescapable aspect of everyday life. They further highlight that managers must realise the importance of possibly rapid changes and they should possess the ability to adjust well, whether a manager is operating a company or an institution. Furthermore, it is likely that changes will only add to a manager's knowledge. (Mintzberg and Gosling, 2002).

3.3 Managing healthcare institutions

Healthcare institutions are often characterised by distributed power, multifaceted goals and a number of players (Prenestini and Lega, 2013). Within such a complex and diverse context, senior healthcare managers are expected to implement the approved strategy. They are even expected to provide strategic direction and lead institutions toward their goals and performance targets. Among the complex issues that managers are supposed to handle, are the effects of new technologies, and the selection of those technologies that provide greater benefits than costs. Managers' tasks include assessment and negotiation of intricate financial agreements and required resources are provided without risking long term fiscal viability (Schein, 1996). Managers of these types of institutions are also expected to mediate internal conflicts between professionals and balance the competing demands of community groups, regulators, contractors, staff and patients, to name but a few (Baker, 2003).

Thus, it is important to set clear boundaries that relate to all the staff members regarding internal matters and principles. Paula Rolfe (2011) points out in her article how important it is for the employees to know their roles, to feel secure, and to be content with the conditions and the work environment. However, weaknesses in this area can affect success and efficiency of institutions. Job satisfaction is also an important factor in this context and can have a positive effect on how successful an institution is in its role. This has been found to increase ambition, interest, and diligence, as well as decrease employee absences. In this sense, the leadership qualities and the communicative competence of executives are fundamentally important and can further determine employee's loyalty and commitment toward the work place (Mosadeghrad and Ferdosi, 2013, Skogstad and Einarsen, 1999).

Shortell and Kaluzny (2006) even go so far as to speculate that institutions that provide healthcare services are unique and distinctive among corporate institutions. They argue that this is especially true when the management aspect is considered. There are several reasons for this, such as because it is harder to define and assess the operational output, and because the issues that are being dealt with are so complicated and varied. This is so also because most of the issues are urgent and cannot be delayed, and because there is low tolerance for mistakes and ambiguity. Further, because the work is quite specialised, the activities depend on broad cooperation between specialist groups, and finally because the work is built up on groups that are by tradition bound to loyalty within the profession rather than to their employer. However, Shortell and Kaluzny specify that healthcare institutions are not completely unique as there are more institutions that operate under similar circumstances, such as air traffic controllers and even the university community. Shortell and Kaluzny (2006) emphasise that general acknowledgement of the distinctiveness of healthcare service institutions may be harmful, especially if it leads to the belief among managers that their work is so difficult, demanding and unique that the work cannot be improved or outside experience is not applicable.

Management reform is a matter that Runo Axelsson (1998, 2000) has covered extensively, especially in light of the vast changes that have taken place in the institutional environment of healthcare services, such as in Sweden. Axelsson indicates that some of the large scale institutional and system changes that have taken place were supported by very limited research, but rather some popular opinions. Moreover, that the researchers in the field have played little part in the evaluation and development of the various institutional models. The problem with all this is that the human aspect has been grossly undervalued during the design, alteration, enlargement, and merging of these institutions. The bureaucracy and technical performance capacity has been valued too highly and as a result the social elements are unsatisfactory. Therefore, there is increasing criticism among employees of many of these institutions. Doctors that are well versed in evidence-based medicine call for a similar approach to the design of these institutions, where theoretical, evidence-based and empirical practices will prevail (Axelsson, 1998).

Edgar H. Schein has made a notable mark on many areas of the field of organisational development and learning. Schein (1996) has examined cultures of management and

made constructive attempts to explain why organisations fail to meet innovations, new demands, attitudes, and techniques with the challenges of a new century in mind. He maintains that among each organisational subculture there are three particular cultures. He calls those the “operational culture”, the “engineering culture” and the “executive culture”. These three cultures, he states, are often scarcely aligned with each other. Additionally, there is a lack of understanding among those types of cultures and therefore they often work at cross-purposes. This lack of cohesion causes the failure of organisational learning. The consequences of this are often inactivity and continuation of less efficient or effective practices. Schein takes an example from the healthcare industry and states that the needs of the primary care physicians (the operator) to do health maintenance and illness prevention might conflict with the engineering desire to save life at all costs. Furthermore, this might conflict with the executive desire to minimise costs, no matter how this could constrain either the engineers or the operators. Schein feels that there is a way to go before the problems of organisational learning and development are solved. He further believes that it is fundamentally important for the executive and engineering communities to begin their own learning process and start structuring the problems of management cultures. This will enable people to find solutions that work for the twenty-first century (Schein, 1996).

4. THE AIM OF THE PROJECT

4.1 Objectives

The modelling of Icelandic hospitals is changing from medical specialities to divisions with unit-based budget responsibilities and improved institutional accounting practices. Efficiency, accountability, transparency, and enhanced management are common goals for the governance reforms in the Nordic countries as well as in other countries in Europe. Ownership structures, financing and payment mechanism have changed alongside the more general aspects of the regulatory structures. Currently, the demands in institutional management are changing as is the case in the leadership structure. Data show an increasing turnover of top management in most of the Nordic countries, especially after the turbulent times and reforms of recent years. However, the problem is limited knowledge available regarding the real effect of governance changes on organisations and their performance. There is a clear need for further research in this field (Kjekshus, 2009).

As mentioned above, there are increased demands for performance, efficiency and more effective governance in healthcare. As a consequence, the need for leadership in managerial jobs and the difficulty of providing effective leadership in such jobs has grown considerably. According to John P. Kotter (1988), this is mainly due to two reasons. These are the dramatic shift in competitive intensity and the increasing complexity of the managerial environment. He argues that each reason is independently having a demanding impact on the current environment (Kotter, 1988).

At the same time, there have been assertions that both the government and the public are increasingly impatient due to the negligent and ineffectual management of the healthcare services and substantial expenditure there (Edwards, 2003). Therefore, there is this increased risk that the discord about funding on the one hand and adequate healthcare on the other will create conflict with the government. The latter generally demands that operational and financial objectives are unconditionally enforced. This is a well-known, and hotly debated subject in Iceland. However, professionals see this as a strain on the acute and sensitive services that are being provided. Therefore, many questions arise regarding the formal and informal communication between administrators of healthcare institutions and authorities as regards the strategy and organisation.

The author has examined material from a variety of sources to figure out whether the scientific community has dealt with real management practices extensively. Much has been written and theoretically studied in the field of management, both in general and specific management areas. However, through the years, the procedures and practices of senior management have actually been studied to a lesser extent, particularly in the healthcare sector. Yet, within the specific field of leadership, there are signs of growing interest, not least as the use of qualitative research method and its impact in the field is beginning to be felt (Bryman, Stephens, Campo, 1996, Bryman, 2004) but not so much in Iceland, however.

The goal of this study is to deepen the understanding of the position of managers of healthcare services in Iceland and to explore the communications between them and authorities. Attitude, understanding and experience of managers will be analysed, as well as the experiences of their closest co-workers and authority representatives.

The expectation is that this project will firstly lead to the development of better practices in the interactions of healthcare managers and ministries. Secondly, that it will explain the nature, weaknesses and strengths of formal and informal connections between those parties. Finally, that it will contribute to more focused and efficient procedures in the management of healthcare in Iceland.

4.2 Aim

According to the job descriptions and the terms of reference formal demands are made to managers of healthcare institutions. It is important that they should have a clear vision of their role in administrating their institutions. A manager should look carefully to approaching changes and future developments to be able to make correct decisions for the operation at every given time. Additionally, an important aspect of the manager's work is policy making in a demanding financial environment. He also has to be capable of bridging unforeseen gaps, for instance when it comes to knowledge, technology and culture. Therefore, adjusting to changing circumstances in an environment that leaves little time for transition is a constant task (Holmberg and Tyrstrup, 2010).

This, in brief, is the basis of the study and the aim is as follows:

To analyse managerial aspects of governance within Icelandic healthcare institutions as regards job descriptions and policymaking plans

To approach the subject further, the following research questions are selected:

- *As regards managerial aspects, what characterises the policy making and governance of the Icelandic healthcare system?*
- *As regards formal definitions and policy making, how are communications in healthcare experienced at various levels?*
- *What are the visible weaknesses and strengths at the management level of the Icelandic healthcare system?*

5. METHODOLOGY

5.1 Method

The subject of a study and the type of answers and information gathered determines the research method. Qualitative research methods are suitable where the knowledge of the field is limited and where the objective is to collect added insight into human experience, communication and values (Malterud, 2001a). Therefore, a qualitative research method has been chosen for this study and data collection is derived from interviews. A content analysis is utilised where procedures and criteria of Graneheim and Lundman (2004) generously guide the way. The reason for this is mainly the nature of the subject matter. Also the emphasis of the study on individuals' experiences, attitudes and positions as regards a topic that has not been researched extensively by theoretical methods in the respective environment (Hsieh and Shannon, 2005).

Furthermore, a qualitative research method was chosen because participants might have a different premise or experience of their situation. Kvale and Brinkmann (2009) point out that a research interview is a professional conversation or a discussion that has a specific form and purpose. The purpose is to gather qualitative data about the individual's experience of the reality he/she is a part of, in this case, the work environment.

Jan-Erik Ruth (1991) notes in this context that the researcher here freely can utilise all the experience and knowledge he may have of the subject, both in terms of scientific knowledge and other sources of information. However, the researcher cannot change the true content of concepts nor disconnect them freely from the context in which they occur. Even everyday experience and literary knowledge is accepted. The main point is to be fair to all information received by the techniques that are applied (Ruth, 1991).

5.2 Design

In this qualitative study research interviews were carried out with administrators of healthcare services in Iceland. The participants expressed their opinions and described their work set-up and the circumstances that have been created for healthcare professionals in Icelandic society. The author defines these interviews as semi-structured and employed an interview framework which allowed participants to express themselves on their own terms and in the way that suited them best. Semi-structured interviews allow the author to get closer to the field of study and during the interviews, the author followed up on those interview questions that were answered generally but needed a more definite answer. Additionally, the author used theoretical guidelines for qualitative research interviews (Kvale and Brinkmann, 2009).

5.3 Participants

There were ten participants in the study, consisting of managers, executives and officials in the healthcare service. In choosing participants the author aimed to reflect a breadth of experience, education, and to find those with a good overview and

knowledge of the country's healthcare service. Additionally, the participants were chosen to reflect a breadth in age, length of service, and those that had experience of both hospitals and primary care. Gender considerations were taken into account. There were equal numbers of male and female participants, even if that is not a true reflection of the gender ratio in healthcare services. Professional experience spanned from one year to approximately 30 years in the field. Representatives from the professions of doctors, nurses, economists and lawyers were in the group. Four of the participants are *managers* of healthcare institutions from various parts of the country. They are responsible to the Ministry of Welfare for all the undertakings of their institutions. Other four participants are professional *executives* at the middle management level and carry out professional and financial responsibilities for the operation in their field. Their participation is justified by their extensive overview of the manager's operating environment. The remaining two participants are senior *Ministry officials* from the Ministry of Welfare, representing the two highest posts of the office with authority and status to express themselves on behalf of the Ministry.

5.4 Data collection

The collection of data began with a brief conversation with the individuals to seek their acceptance in taking part in the project. Afterwards, an email was sent and an affirmative reply was considered a formal acceptance of their participation. The individuals that were contacted all expressed great interest in the project and a willingness to participate. After their participation was confirmed, a letter was sent to each of them with a brief presentation of the study and the subject matter (Appendix 1).

All of the interviews took place at each of the participant's workplace, at a convenient time for them and in their private offices.

Before the interview officially began, participants were made aware that they were free to ask for a break in the proceedings and that, if requested, any particular statements of theirs could, if needed, be corrected or clarified at any time. However, no participant made any such requests. Additionally, there was emphasis on creating a comfortable and relaxed atmosphere where there was trust and natural communications (Kvale and Brinkmann, 2009).

The author followed an interview framework, with a few variations depending on the development of the interview process. The framework was also tested in a trial interview (Appendix 2). The interviews were recorded on an audio tape with the participant's informed consent. Each interview took between 55-70 minutes. As each interview was concluded, the author tested the audio quality of the recording. The data was labelled with a symbol and was not accessible to anyone other individual than the author during any part of the study. The interviews took place between the 5th of March – 19th of March 2014, and by April 2nd their transcribing was complete.

5.5 The author's role and position

This project was sparked by the author's working experience of approximately 30 years in the healthcare and social services in Iceland. During that time he has been a director of social affairs and a manager in both healthcare and care of the elderly. The author also has a special interest in efficient public service, as well as in progress and development in the field generally. The author is furthermore interested in the improvements available for both clients and employees, and the importance of responsible financial and operational administration in the field.

Because of the author's long professional experience he is familiar with most of the participants in the study and has had personal contact with them before, mostly work related, though. It must further be considered that this could have affected the project's approach and results of the interviews (Kvale and Brinkmann, 2009). The author tried to keep this in mind throughout the research process and ensure that preconceptions, personal attitude, and opinions would not surface and affect the data analysis and interpretation.

5.6 Analysis

During the transcription the author utilised the interview guidelines from Kvale and Brinkmann (2009), which state that pauses, laughter, inflections, gestures, unclear pronunciation and errors should be identified in the text. This laid the foundation for the analysis of the data, even if formal analysis did not begin until the transcribed text was complete. Furthermore, the author listened to the recordings multiple times, compared them to the transcriptions and corrected if needed.

Qualitative content analysis is not an absolute or isolated concept but it does capture a number of methods for systematic data analysis. Graneheim and Lundmann (2004) have presented a comprehensive overview of concepts connected to procedures, interpretations, and measures to achieve trustworthiness in qualitative content analysis.

The analysis process was mainly as follows:

1. Transcribed interviews were read a number of times, and then the recordings of the each interview were listened to. This was done to get a feel for the material, get an understanding of the content, and to analyse the overall effects. Alongside the reading, some comments and speculations were noted down.
2. Next, the author determined the meaning units. According to Graneheim and Lundman (2004) these units are comprised of words, collection of words, sentences or quotes that refer to the same meaning or are interlinked. The units of analysis were underlined in the transcribed interview.
3. Then, the author condensed the meaning units, without them losing their core substance. This is referred to as 'condensing' and results in a more compressed text (Graneheim and Lundman, 2004)
4. Following this, the meaning units were transferred over to a particular Excel document to work on further.

5. The categorisation of these data was then grouped together under higher order headings, the substance of the text further processed, and the interpretations summarised or the content described. This falls under the concept of abstraction which entails both description and interpretation. The more a text is condensed, the more the findings are based on interpretations. The results of summaries or rewritten text are referred to here as coding, as a synonym for a group of meaning units.
6. At this stage, the researcher looked at the codes and considered which of them were alike and which were different. They were then organised into subcategories and those categories grouped in light of what the text had revealed. The last stage of the analysis process was then to combine the underlying meaning of all categories into a topic.

According to the criteria set by Graneheim and Lundman (2004), the key element of qualitative content analysis is creating categories. Furthermore, all important analysis data should be categorised. Graneheim and Lundman (2004) further point out that no data should fall in-between categories or into more than one category. These matters can be considered as the standard quality demands of data analysis.

The author's procedure began with the placing of stickers on a large board, according to the analysis of condensed meaning units into categories. Obviously, this was a time consuming process as it required continual modifications and improvements. But this was due to the crossover between analysis, reading and discerning of interview transcripts, and examination of analysis data. The author also had to consult theoretical guidelines and sources. The final stage is to interpret the results that have been obtained according to the research questions and the theoretical framework (Cole, 1988).

In the working process, a researcher must always be mindful of and utilise strategies to question findings and interpretations instead of taking them for granted. He must also evaluate both their internal and external validity instead of judging them as absolute (Malterud, 2001b). The procedures demand constant automatic action and that care is taken as regards possible preconceptions.

5.7 Ethical considerations

As Kvale and Brinkmann (2009) have pointed out, it was necessary and appropriate to consider ethical issues during all stages of the project.

The objective of this study was to shed a light on the managerial environment of healthcare institutions. This was done through the collection of interview data that in some instances revealed personal and sensitive information that could affect a participant's work environment.

Confidential information that reveals a participant's age, sex and employment are preserved but is not revealed. A fundamental aspect of the study was to assure the participants that their involvement was entirely confidential and that the data collected in the interviews would only be used in the study, in accordance with its objectives and

the previously ascertained informed consent. Therefore, a further description of the participants than the one in the chapter 5.3, *Participants* is withheld.

As interviews were being transcribed it was deliberated how sensitive confidential matters and anonymity can be, especially in a small community such as Iceland. Also, the group of managers in the healthcare services is not particularly large. Therefore, it was challenging to interpret the findings. The author even contemplated asking the participants what they thought of his findings, and how much he should tell them and in what context they should be informed of his findings. However, this was abandoned, mostly due to time constraints.

It was made clear to all participants that their participation was dependent on their consent and that they could, at any stage, retract that consent, which would result in the deletion of their data.

This study did not need clearance from the Data Protection Authority nor from The National Bioethics Committee but they were informed of this anyway.

5.8 Reliability and validity

Reliability refers to how trustworthy, consistent, and reliable the findings are, and if they are transferrable over to similar circumstances or environment (Kvale and Brinkmann, 2009).

Validity or credibility refers to if the researcher manages to capture the most valuable and appropriate information. Thus, the data accurately reflects the subject matter and provides the answers needed. If the data captured adequately reflects the study's subject matter it can be claimed to be valid. The validity of the research is created by utilising the correct research method based on the research question(s), and then attempting to evaluate the research process as it is under way (Kvale and Brinkmann, 2009). Because the author has strong links to the health sector, it was a particular challenge to avoid bias and any hidden skewing of data (Malterud, 2001b). To ensure the validity of this study, the author therefore sought to attend to it with modest integrity and moral responsibility.

Internal validity refers to if the data and the conclusions drawn in the study are perceived as true or correct. In social sciences it is normally difficult to describe what is objectively correct. However, the closest a researcher can get to the truth is when several people agree that there is a correct description. The term intersubjectivity is utilised in this context (Kvale and Brinkmann, 2009).

The only thing that can be said with some degree of certainty is that the perceptions that are described in this study represent the informants who participated. Those were representatives of the three levels of healthcare and they have a good overview of the subject. These participants should also have the knowledge and experience to give a realistic picture of their situation and answer the questions that were submitted in a reliable way. The assessment of the author is that the informants were genuine and honest in what they contributed. This should help to strengthen the study's trustworthiness.

One way to aid validation of the analysis process, and which is not utilised in this study, is to discuss the results with participants. Perhaps such a communicative process would have given greater credibility. Another viewpoint is that there is a risk that the researcher could be affected in such a situation. If he did discuss the results with the participants his views and the quality of the study could potentially be weakened. In order to further promote validity and reliability, the author maintained a consistent framework in the interviews. The author was also precise in all transcriptions, and kept records of who said what. Furthermore, by completing the data collection in only a couple of weeks, the risk of focus shift was reduced. The transcription of data was done by the author himself as recommended. By doing so he gained a thorough perception of, and closeness to the data and avoided some risk of misinterpreting (Kvale and Brinkmann, 2009). The quality of the study may have been weakened by the fact that the author is untrained in the role of a researcher and his lack of professionalism may have affected, both the instruction, interaction and information. However, the author is considered to have some limited experience in similar studies and work experience in interview situations and therefore it is assumed that this effect was barely significant. On the other hand, writing this study in a foreign language might raise some questions regarding validity and reliability. Undeniably some essences in phrases and comments are difficult in translation and the risk is that some of these may get lost.

Generalizability in this context may not be relevant. The term refers to how much the results of the study can be applied more generally and widely, that is if you can generalise the results (Kvale and Brinkmann, 2009). In qualitative research it is almost impossible to generalise, as findings are connected to specific participants and specific circumstances as in this study. However, a concise description of the methods and the research process are meaningful ways to ensure transparency. As a result, outside researchers have the opportunity to evaluate the research process and the validity of the results.

6. Results

Analysis is split into three major categories and nine subcategories. The major categories were the following: 1) *Policy making in healthcare*, 2) *Communications and organisation* and 3) *Strengths and weaknesses*.

In this chapter the contents of the major and sub categories will be covered.

Table I: *Major categories and sub categories that appeared in the analysis results*

Major categories		Subcategories
<i>Policy making in healthcare</i>	6.1	Pledged policies and their manifestation Politics and budget A manager's role and position
<i>Communications and organisation</i>	6.2	Managers' experiences Working relationship with the Ministry
<i>Strengths and weaknesses</i>	6.3	Work processes within the institutions Community support Definitions and responsibilities Empowerment

6.1 Policy making in healthcare

Various issues can affect the execution of a strategy, as interview analysis reveal. These issues are, for example, influences from political forces and an institution's budget resources. In these circumstances it can be challenging for a manager to react to a wide range of demands and different points of view.

6.1.1 Pledged policies and their manifestation

An analysis of the interviews showed that the governmental policies for healthcare services were on the participants' minds, especially of those who work in healthcare institutions. Those participants feel that the role, policies, and long-term vision of healthcare institutions are unclear. These terms, 'role' and 'policy' are the ones most commonly mentioned in the interviews and form a central theme in the results. A Ministry official partly agreed with the attitudes of the healthcare managers. This official for instance said that there had been difficult conditions in the country in the recent years which had prevented the Ministry from establishing a binding long term course of action:

"... but there is a great appeal for, and I understand that completely, a plan that is longer than only 365 days".

The managers further explained that under these circumstances they had nevertheless tried hard to set their own policies and sought approval from the Ministry. However, analysis showed that there were differing opinions of this set up, and that it was ineffective, costly and gave false hopes. There were even examples of an institution that

had, during a ten year period, sent up to five policy making suggestions and these were never approved by the ministry.

The managers pointed out the current provisions of the healthcare laws and the regulations regarding the local healthcare regions as the Regulation on healthcare regions no. 785/2007 covers (Ministry of Health and Social Security (2007b)). There it appears that the regions have considerable say in and responsibility as to how healthcare services are carried out. However, this provision had only been implemented to a very limited extent. One of the managers puts it in this way:

“ ... and I have always said the authorities never got so far ... to finish, within quotations, the policy making on organisation and reform nationwide ”

Another manager believes that the unclear policies and vague definitions of work roles in healthcare facilities nationwide have become a burden. Furthermore, the manager believes that such uncertainty affects staff and morale, and therefore it becomes even more difficult to create stability among this group of professionals when the immediate fate of the operation is hazy. Staff generally calls for clear approaches and some vision for the future:

“...and often I have felt as if we are just a piece of cork floating in rough seas, because you go from the one end to the other with the institution and service and staff and ... you kind of never know what course you are on ... ”

With the executives, their views of the policies, the understanding of the role of the institutions in the Icelandic health system, and the Ministry's vision were even more unreserved. One of them stated:

“...this cannot go on much longer because we need to continue and people are burning out and we need a clear course of action from the authorities ... ”

However, Ministry officials spoke with different emphases and denied statements of there being uncertainty in the healthcare service policies in Iceland. These maintained that the policies were clear and that the problem was not a lack of policy but rather that the managers of healthcare institutions did not accept following the Minister's policies, and a Ministry official said:

“Some try to fight this and say, I do not want this policy, - I want something different. Then they always say that there is a lack of direction because they do not agree with it ... but currently this policy is very clear but some just don't accept it.”

A Ministry official mentions the debate on this same aspect:

“It is classic to call for it, it is a kind of cliché that everybody uses under pressure and then people are simultaneously trying a little to absolve themselves of responsibility ... ”.

6.1.2 Politics and budget

The influence of politicians on the operations of healthcare institutions seems to be very noticeable, both at a municipal and national levels. The interview analysis clearly

indicates that this is the case. This refers to both professional and financial matters and it is most commonly noticeable in matters of dispute. At such times the communications from the Ministry seem to get carried away. One manager mentions the interference of politicians via the Ministry. These situations put the managers in a difficult position and can make it almost impossible for them to operate the institution within the budget:

“...and it has of course happened here more than once and more than twice, that both the Minister and politicians interfere with or oppose particular changes ...”

The executives agree about the importance of the Ministry in its role of a policy maker. However, it is noticeable how surprised and disappointed they are over how easily the Ministry veers off course and into micromanagement. This is reflected in this quote from one of the managers:

“... The Minister and the Ministry should of course first and foremost attend to the policy making and the service framework but not take part in the execution...”

Regarding the plans and suggestions of healthcare managers to streamline and economise, a Ministry official said:

“...this has often happened here and we have instances of, for example, closures that we have not accepted. Those suggestions from managers have been something that has been overruled ...”

The results show that the executives consider it very important that there is trust between the institutions and the Ministry and that those standing behind the institutions, i.e. the Ministry, provide concrete support. It could be discerned from the interviews that there had been lapses in this matter and it clearly was on the executives' minds. The participants also indicated that the Ministry often lacks direction and resolve in challenging matters and often caves in to political pressure. One of the executives is displeased that matters are not handled better:

“...ideas on streamlining are always taken off the table because they don't fit in...for some reason...because you belong to this political party or are involved in municipal politics or you are this or that...”

A Ministry official said that as regards political pressure and permissiveness, the Ministry often was in a very tight situation concerning the solutions to problems of individual healthcare institutions. Consequently, it could at times be difficult to know what to do. The official provided this explanation:

“...often these are important workplaces and there is regional pressure that usually results in that one not venturing....one not wanting to take certain actions, it is just the fact of reality...”

The interviews clearly reveal that the managers realise their duties of operating these institutions within their budgets. However, when things get tough there are a limited number of recourses available, except decreasing operational costs by reducing staff or making substantial structural adjustments. Additionally, there has sometimes been friction between the institutions and the Ministry because of the options the managers have suggested. Subsequently, the managers feel as if the Ministry's involvement is

diminishing their possibility to look after the operation. One of the managers describes it in the following way:

“... I say that as far as we are concerned, and of course this happens elsewhere, when these proposals are formed people are naturally trying to form proposals that have as few disruptive effects on the service as possible, cause the least amount of weakening to the service ...”

The position of the Ministry official on the described recourses of managers can be deduced from the following comment:

“I am completely familiar with this...they introduce proposals which they somehow, you just don't believe they think that anyone would agree with them and then they coerce forward some other solution, either more money, because this wasn't agreed on...or they get themselves out of making decisions like this and it falls on to someone else to take...”

Recently, due to decreased budgets or operational changes, the executives have had to face using some reduced recourses within the operation. However, public workers are to a certain extent protected by law. This means that it can be difficult and time consuming, and a delicate process to lay anybody off or make major changes. This is significantly different from what can take place in the open labour market and further creates difficulty, not least when decisions are made with short notice and the budgets only allocated for a year at a time.

A Ministry official referred to the laws for the public workers in the following way:

“...we are in the position here that it is not easy for managers to clean house. As people have tried to bridge the gap, the position of the public employee seems to just have continually moved away from the one in the open labour market.”

One of the Ministry officials believes that the position of a manager in a particular service region can be complex and may lead to a choice between two options, i.e. staying true to the Ministry or trying to set their own course in maintaining operations. The latter is sometimes resorted to even if the funding for the operation is not guaranteed. A manager's position in some region or area where expectations tend to be high and where he is even well respected may become difficult for him:

“... and they retreat into their local region to various extents as they cross this threshold on their way home...and in the Ministry's opinion some have had too much problem with this and not perceived themselves as the agents or representatives of the Ministry...”

One manager thought he knew examples of financially unsound decisions that his colleagues had made:

“...but these decisions are still made because they perhaps realise that they will not lose their job and will not be hung out to dry because despite the responsibility, the penalty framework...even if it exists, probably no sanctions are applied ...”

6.1.3 A manager's role and position

The analysis shows that executives think that managers have extensive responsibilities although these are not always very well defined.

A Ministry official says following about a manager's job:

"...it's a difficult job and those who undertake it should be clear about that, but I think that the demands on the managers are not unrealistic ... in theory it has sometimes been said that running a hospital is one of the most complex things that people can undertake."

Interview analysis results seem to indicate that the Ministry believes that the relations with the managers are generally normal and that although the demands are challenging the job description and the terms of reference are clear. Also, it is implied that there has been some slackness in the management of operations and this has led to problems, and that there has been a lack of confidentiality on behalf of the managers to the Ministry. There has, however, been some positive development here. The Ministry's position is that managers should be independent and have the freedom to shape the operation. A Ministry official describes his position as follows:

"I believe that naturally managers should be able to show some initiative although it is not strictly put down on paper what this "initiative" should be ..."

The managers were asked about what options they had now to make managerial decisions in their job. One of them called attention to how complex, demanding and untraditional the managerial environment was in the healthcare system:

"...a manager has in reality both responsibility and authority... It is very clear, in my opinion, that there are certain professions that have a very strong position as regards controlling and steering things towards what they think suits best for their position ..."

A Ministry official reflected that it varied somewhat how a manager's efforts and practices were compatible with the needs of the pertinent institution. The official felt that it was certain that all of them wanted to do a good job for their institutions:

"...but they have to uphold a certain policy direction set by the Minister, which can be difficult for them; it sets certain demands on them."

The managers mentioned that their general possibilities were not up to certain modern standards and dissimilar to the situation on the open labour market. One manager stated that there were considerable dissimilarities in all this. A ministry official felt that, in a sense, the management confines are unacceptable:

"The weaknesses are perhaps that the information systems are being formed, and still remain limited. The finance systems need to be improved..."

6.2 Communications and organisation

Communications and organisation were aspects that repeatedly surfaced in the interviews and it was clear that the turbulent economic circumstances of the recent years have had some effects. Those who work in healthcare institutions believe that good

communications, both internal and external, are the key. Generally executives experience communications between public officials in different ways. Executives believe such communications should be formal and effectual.

6.2.1 Managers' experiences

From the interviews and their analysis it can be deduced that managers feel that there is a considerable distance between them and the Ministry and they also feel that communications with the Ministry are generally onerous and negative. One executive expressed openly a dislike of the Ministry's criticism of a manager's work, alleged lack of control and direction when it came to financial management:

"... but they don't want to say anything then about what we are supposed to do, ...how can you deal with this criticism, stating that a manager is not meeting demands made of him? This is obviously just...it cannot work..."

Another executive mused on the debate on managers' lack of discipline:

"... but then really there is nothing...no one is reprimanded...yes, of course perhaps reprimanded but that is also it. So you also wonder...are these also ambiguous messages from the Ministry...?"

A Ministry official confirmed that they were familiar with these issues and one of them said in reference to this:

"There are many that get a talking to, ...but I think we are well aware of the options and we have to dismiss them...there have been harsh talks with managers, ... they are not very threatened by these, not even the Minister's words...it isn't easy to fire a manager, it is almost impossible..."

A Ministry official also states that there are instances where managers work considerably outside their regulatory duties and are not always focused in their roles and decisions. However, most of the time they are very clear about what is expected of them:

"Yes, it happens in some instances...and sometimes I wonder about some activities that have taken place. Perhaps there should have been stricter penalties for them but a gentler approach is often tried..."

Trust, confidence, warmth, and kindness are terms that the executives considered to be important characteristics of a manager. One executive stated:

"He needs to connect with the staff and gain their trust. The most important thing for a manager is to create trust between himself and others within the institution, and he needs to be credible..."

6.2.2 Working relationship with the Ministry

Analysis shows that the communications and working relations with the Ministry are both formal and informal. They can be in the form of letter writing, meetings and conversations. No formal practices or procedural rules are in effect and institutions have, for example, no means to see what happens with the tenders they send to the

Ministry. One of the managers believes that there is work left to do in connection with the communications between institutions and the Ministry and describes own experience here:

“... these are perhaps a little superficial at times. There are scheduled manager meetings perhaps once, twice tops, a year...and there are little to no communications ...”

Executives in healthcare institutions normally only have indirect relations with the Ministry, usually through the intermediation of the manager. Yet, representatives of the executive board sit at least two meetings a year with the Ministry employees.

“... I feel as if these are usually discussions that are somewhat superficial...and you leave with more questions than you do answers.”

Ministry officials agree with this point of view and one states that the working relationship needs to be tightened, procedural rules improved and...

“...that the authority of healthcare managers should be increased and responsibilities of managers as against those of the ministry must become clearer, the dialogue needs to be more profound.”

One manager points to the discretionary relationship with the Ministry and that all managers should be clear that they are the agents, or the extended arm, of the Ministry in their region:

“ ...but it simply will not, at least in my opinion, work that managers are in a kind of war with the Ministry, at least not publicly. People should just discuss these issues directly with the Ministry but not through the media.”

Ministry officials are certainly familiar with the communication pattern described above and one of them says:

“...we have had to deal with managers working in such a manner that they were activating local resistance towards us, that’s for certain...and then it hits us here, everything from signed petitions to a group of aggressive people showing up...”

One executive is of the opinion that communications are the most important aspect of everyone’s job. This is regardless of whether those communications are within the institution or if they are also true as regards things outside the institution. This executive also describes how communications between a manager and the Ministry is experienced:

“...I think that this is the biggest stress factor in the manager’s work, that is to say, to deal with decisions he doesn’t want to tackle but which he has to deal with.”

Another executive expressed concern over the limited connection he has with the authorities, and in the same sense the limited support managers have from the authorities:

“... I feel like the communications between the institution and the Ministry are a bit one-sided and a bit We and You ...”

The interview analysis clearly revealed that collaboration and communication in connection with solving problems is of great value to all employees. Also the Ministry needs to take the initiative in this respect. There is an assumption that the Ministry has a wealth of specialist information and relationships that generally are not found in the institutions. However, the institutions have available a different kind of experience that the Ministry can utilise for problem solving, or as one manager put it:

“...I think it is very important to activate this force, bridge the gap. It is perhaps in some sense not bridged yet or poorly bridged...”

Another manager also emphasised the importance of the Ministry having the human resources and experience that can benefit those that work in healthcare institutions. A chasm seems to have been formed between the knowledge of those that sit at a desk in the Ministry, and the experience of those who work on the floor or out in the fields. This is often discussed among managers:

“...and it must be extremely important for this type ministry to have employees that have worked in this sector... yes, it isn't good if the largest part of the workforce has never worked in a healthcare institution.”

Finally, the results showed that managers and executives believe that communications with the Ministry are too focused on financial matters and that policy making and professional issues are neglected. One manager expressed this quite heatedly:

“They of course had their Excel spread sheets and the numbers ... I feel that there is a lack of knowledge, definitely in the Ministry, professional knowledge and interest.”

6.3 Strengths and weaknesses

Some flaws that executives feel affect their success, are apparent but these flaws are not manifestly connected to the budget or interference from the authorities. It is on the agenda of institutions to be well connected to their near community as the community may at times provide the institutions with valuable support. It is also a fact that when it comes to social communication the smallness and personal relations make Iceland distinctive.

6.3.1 Work processes within the institutions

In the interviews there were marked differences between the participants' feel for the work processes and the organisation within institutions. On the whole, managers believed that generally the organisation and work processes were fairly clear and unflawed. However, the executives, who worked more closely among the staff and the clients, experienced more flaws in these aspects. In all instances there was in effect an organisational chart, even if examples showed that it did not accurately reflect the actual work structure. Managers expressed that well defined jobs led to improved success of the operation. One manager further stated that the majority of executives have a great responsibility, not just professional but also operational. Regarding working procedures, an executive disclosed that in his opinion roles and work purview are generally

inadequately defined. He further admitted that this is disadvantageous and decreases success and efficiency in the operation.

One of the managers implied that the culture of ‘*we are going to sort it out*’ had been thriving in the system for too long. He further disclosed the various management practices of professionals that are established in the entrenched habits and operational organisation of the healthcare system:

“A much clearer, ideological vision among doctors is lacking. The money-man thought of things from his point of view and same goes for the nurse, who was perhaps the one who was most aware of the value of cooperation and collaboration...”

6.3.2 Community support

The interviews revealed that there are outside forces that influence the operation of the healthcare institutions. They also revealed that the relationship between the institutions and the community are constant and alive, and that managers try very hard to meet expectations and demands in that field. Findings also showed that managers try to draw attention to the valuable support that various community groups show the institutions by donating large gifts every year, both in the form of funding and equipment. Also, all over the land there are a number of organisations of local residents that watch over the operation. One executive says it is always bad to get negative press but they try to answer all comments and explain matters to limit the damage and inconvenience of such press. An executive mentions an example of this:

“... we have then gone out and responded and provided something positive into the community, and tried to cooperate amicably with the local papers and media...”

An executive mentions the effects of the local debate and the importance of having the operation and staff supported by the local residents:

“... Look, the community can completely overturn us if it decides to do so...there are communities that reject their own institutions and...attack them and that is exactly what we are experiencing here...the employees are constantly on the defensive and it affects the service...”

A manager described own experience of having to start work as a stranger in a community where there had been unrest due to the development in the service and mediation had to take place:

“... and then I experienced a great deal this differentiation and what like the closeness was great, and what it was severe, critical and political biased and how the dialogue was based on little professional knowledge...It was like a new world opening up and you wondered, how a person could approach this without completely losing one’s professional dignity?...”

An executive believes that the main problem is crystallised in the vague definition of the institution’s role; it is in a type of self-identity crisis. Furthermore, the same

executive believes that in circumstances like that, there are outside forces that see an opening:

“...and then they have ample opinion on the subject. And we feel that those opinions are just very poorly thought through...and in no keeping with what we feel as executives, both in terms of what’s most economical and sensible and what is fair to do, for instance as regards disposing of funds.”

One manager points out the distinctiveness of Iceland when it comes to social communication, and how the great closeness and smallness there affects everything:

“Thus, as soon as something goes wrong then perhaps one family member appears in the Minister’s office or the office of a manager in the community, practically with his fists in the air...This closeness often makes it difficult to maintain professionalism ...”

6.3.3 Definitions and responsibilities

In interviews with the managers it could be noticed, that the contract, the terms of reference was not really on their minds, but one manager referred to the content:

“...I think it is fairly clear and of course you try to work in accordance with it. It is obvious that...the main problems have to do with the finances...to make it all work”.

The interviews also revealed that most of the executives had not been given a chance to familiarise themselves with the manager’s terms of reference and did not have his actual job description handy. One executive said in jest:

“The manager is kind of just supposed to do everything that the others do not. That is kind of, in my mind, not more outlined than that...”

A Ministry official clarified that in own opinion, the terms of reference and job descriptions should be phrased in more general terms. The Ministry Official also stressed that the managers ought to have a clear idea of what their roles were, and added:

“...without a doubt, people call for enhanced and clearer definitions in times of trouble, but otherwise I think the job description fits the more general definition of managers.”

Data analysis showed that job descriptions are on hand for most jobs. However, this is not infallible and executives feel that this area needs improving. By improving effective workmanship and morale, the success of institutions could be positively affected. One executive believes that roles are not defined enough in his institution. This he feels leaves staff with too great a freedom to choose tasks. As a result, the workmanship becomes ineffective and the service less professional and safe:

“It depends a little on the type, what he/she does, perhaps he/she can get away with picking and choosing...because things are not defined clearly enough ...”

Another executive traces the operational difficulty and labour shortage partly to the fact that the division of roles is so vague and says that some executives take on many roles:

“...we are trying to divide the tasks between us and this has caused the boundaries to become unclear, the people don't quite know where to go ...”

6.3.4 Empowerment

In the interviews the executives repeatedly indicated the necessity of harnessing initiative and calling on their staff to take part in important matters. They also felt that the employees should take on increased responsibilities and strengthen their empathy and understanding of the importance of effective management in healthcare services, both in professionally and financially. According to interview analysis, this idea of empowerment has already started to take hold in the institutions of the healthcare system. This was evident in how executives are taking on increased responsibilities, but both the executive directors of nursing and medicine used to primarily see themselves as professional superiors. However, this has changed and the executives' responsibilities now cover both professional and financial aspects. Department heads also have these increased responsibilities. Managers further explain in the interviews that now all executives are well aware of these matters and realise that for the good of the operation it is necessary that these aspects go hand in hand.

Analysis also indicates that the ideas of empowerment are prevalent in the Ministry's policies as one of the Ministry officials stated:

“We look a lot towards the expansion of institutions; large institutions with a reinforced internal management system that do not need to come to us with these occurrences and can comply with the demands that are being set.”

A Ministry official adds another matter that should further bolster empowerment within the service, with regards to the division of tasks between the Ministry and institutions:

“...but we have to try and get rid of those projects that are time consuming and are better at home elsewhere and some possibly within the institutions.”

On the topic of decentralisation and empowerment, a manager explains that within wide-ranging and dispersed institutions, this is often not even a choice:

“You have to be ready to let go of as many projects as you can...and try and get others to shoulder the responsibility as is possible, but you have to manage it...”

A manager of a certain institution elaborates on the steps that have been taken in order to strengthen executives in their tasks:

“...and, for instance, a course for all executives here is about to begin...people are very positive towards it and just think it is very good and that will reinforce the executives in their work.”

An executive says that he tries to encourage employees in their day-to-day tasks and he has the tenets of empowerment in his mind when he further states:

“Power is delicate, teamwork is important and there are leaders everywhere. The spotlight shouldn't always shine on you or the one in charge. A manager should make sure that the spotlight is on the members of his staff...”

Another executive paints a picture from the work environment that indicates the seeds of empowerment:

“I think it is very pleasant if I can present things in such a way that people are excited to take part in the project.”

Lastly, one of the managers is reserved about tying himself too much to theory when it comes to day-to-day management and says:

“...I think that people have to be careful not to become square shaped or stuck in one box because this is...it is just so dynamic.”

7. DISCUSSION

7.1 Result discussion

In this study three main categories were identified and further nine subcategories. The main categories were “Policy making in healthcare”, “Communication and organisation”, and finally “Strengths and weaknesses”. These along with subcategories will be discussed further in this section.

Policy making in healthcare

Many administrators, both managers and executives, have in recent years criticised the authorities over the vague and ineffective policies for the healthcare services. This, they state, creates uncertainty about the role and operations of healthcare institutions in some regions. Their criticism is not directed towards the framework of the law and regulations themselves but more against the execution of these, the perceived attitude of the Ministry and the lack of transparency. Also, multiple reports over the years (The Icelandic National Audit Office 2009, 2013) indicate that the financial difficulties of many institutions can be traced back to this lack of direction and that the institutions do not know what they should tackle and what they should set aside. Meyer (2008) points out that often there is a desire and ambition to stay focused and be targeted. However, despite the fact that administrators, i.e. managers and executives, spend countless hours planning and trying to implement their organisation’s strategy, they have little success. The reason might be that the strategy is not clearly communicated to the employees or is too vague or complicated. The findings in this study, in various respects, indicate that this might apply to administrators of healthcare institutions in Iceland, at least as regards the Ministry.

Results seem to reflect that short-term plans are prevalent and a long term vision is overshadowed. This is actually in direct contradiction to what can be gathered from the Ministry officials. They state that the strategy has rarely been clearer than just now. This gap in opinion is noteworthy and seems to have some characteristics of communication failures, somewhat as if the alleged policy has not been developed in appropriate collaboration among all parties. The findings also indicate that the Ministry has not managed to clearly communicate to the healthcare service what is the planned course. It may well be that the managers simply do not accept policies issued by the ministry, as ministry officials have suggested. As shown above, managers are reluctant to agree to changes and even seek to operate in a manner not in keeping with the Ministry, despite this resulting in deficits of operation. This might be regarded as some kind of a resistance as Paul Strebel has mentioned. He also argues that senior managers, when seeking acceptance for changes, consistently misjudge the effects these changes will lead to. The senior managers also misjudge the chasm it creates in the relationship between them and subordinates (Strebel, 1996). Whether this applies at a governmental level is unverified.

Managers of healthcare institutions, as other public supervisors, are supposed to fulfil their duties by following the Minister's terms of reference. They are responsible for the operations of their institutions as managers on the open labour market. It was observed from the findings that managers are willing to do their best to adjust to conditions and instructions of the Ministry, even if they are operating within strict boundaries. The managers consider the requirements of the Ministry to be very tough and to some extent unrealistic. They also feel that the Ministry's requirements present an unclear vision. Such circumstances would be very burdensome for the management and all employees. This actually is in line with the aforementioned Shortell and Kaluzny's (2006) opinion on how the role of a healthcare institution's manager is especially demanding due to the complexity of these organisations as a whole. However, as a general rule, there is little consideration for this in their work platform, neither in their support system when it comes to problem solving nor in employee benefits. Henry Mintzberg's research further supports the supposition that the administrative tasks of managers can be demanding in various ways depending on their field of work. Mintzberg has investigated the work environments of 29 different managers from diverse professions, including healthcare services. His findings indicate that the type of institution being managed is a bigger challenge than some different aspects, which other scholars have often focused on, such as management style and specific localised features (Mintzberg, 1975, 2009).

It can therefore be speculated that excessive demands and incomplete support structures might somehow explain media coverage of frequent changes in the management environment and increasing turnover (Kjekshus, 2009). Such coverage has surrounded many institutions in healthcare services in some of the Nordic countries. Furthermore, this may be indicative of the calls for better organisation and stronger vision in the field that have come from Icelandic administrators in the healthcare services.

Short term solutions and an unclear vision, which administrators experience so clearly, raise at least some doubts in this respect. Still, what seems clear from the interview analysis is that administrators are not successful in upholding the course that the Ministry sets, and insists is clear. Processes seem poorly defined and it proves to be difficult to implement the policy that the Ministry demands of the managers. This hardly appears to be in line with the goals of management by objectives (MBO) previously described (Drucker, 1974). Motivation, organising and employees' development are key issues in this respect. Findings indicate a high demand for clearer definitions and that achievable objectives should be set for the entire country in consultation with interested parties and in particular, administrators within the sector. According to findings, managers do not experience a fluent and continuous debate on the role of healthcare institutions, neither in projects nor priorities that can ensure the quality of health services in both urban and rural areas. Temporary economic uncertainty was the main explanation for little initiative on the part of the Ministry, as was seen in the analysis of data. However, these explanations are hardly valid as increased funds are only diminutively connected with the debate on strategic planning.

Strategic management has been developing in the past century, though particularly in the past forty years (Steinþórsson, 2003a). These theories of strategic management are well known in Iceland but have not been implemented in the environments of administrators in healthcare, at least if the managers' experience in this study is to be

considered. The findings show that the Ministry feels the trend in healthcare in Iceland is fairly clear at the present time. It can further be interpreted from the results of the study that a kind of a strategic management is enforced by the authorities. Nevertheless, findings indicate that major elements of the strategy do not appear to be properly enforced, according to both the assessment of the Ministry and managers. It should be kept in mind, that although this has been the case, there is no guarantee, that the intended policies of the Ministry would have been better implemented, compared with the experience of many companies and institutions. It has been revealed, as policies run their course, that there is often a marked difference indeed in what has happened and what was supposed to happen (Steinþórsson, 2003b). However, that may be, partly due to this, the starting point should be soliciting some involvement of employees, clients and other interested parties to shape a realistic and achievable strategy for the whole country. A strategy, as an emergent phenomena might be considered as a viable alternative. While this may sound like old methods in new wrapping it may, however, represent new and exciting opportunities for authorities and administrators in healthcare.

The findings in this study revealed that the Ministry believes that there has been an unacceptable lack of discipline in financial control among managers of healthcare institutions. In some isolated instances, stricter penalties could have been applied, even if the gentler approach was deemed adequate. Findings also show that executives and managers are aware of the financial responsibilities inherent in the job. At the same time they openly admitted that they knew about some instances where obligations to enforce a budget were violated. They defend these actions by pointing to incomplete financial systems, insufficient funding by the government and the continuous or mandatory requirements to maintain and improve service at local levels. Schein's reflections of three types of cultures in organisations and their lack of alignment to each other are illuminating in this context (Schein, 1996). Mutual understanding or agreement does not seem to be present. Finally, findings indicate that managers and executives are indeed a little surprised that the Ministry does not utilise their capacity for sanctions when things go awry.

The coverage of The Icelandic National Audit Office (INAO) (2007) in one of its many reports is noteworthy in this respect. The Office has performed audits, sought explanations for operational difficulties, and spoken to managers of particular healthcare institutions. They have done this either with initiative from the authorities or from the institutions themselves. One such report, Implementation of Government Budget in 2006 (2007), states, that there is a certain pattern in the explanations that the managers present for the deficits of operation. The pattern is this: Firstly, a manager believes that added funding is needed and requests more for the budget. Secondly, this request is turned down and a manager then reveals to the Ministry that he needs to make some cuts in the operation, so that it falls within the budget. Finally, the Ministry generally requests that the manager does not make cuts in the services as there are plans to remedy the financial difficulty. Even if the Ministry's requests are rarely in writing, managers believe that this is an offer in good faith of the Ministry's intention of securing additional funding from the next general budget (INAO, 2007). It comes therefore as no surprise, as the INAO's report states, that the Office is open for interpretation if the communication and directives from the Ministry are in fact clear or

vague. As a conclusion, the INAO finds that the problem not only lies in the lack of discipline of managers, but also in the omission of executives of those ministries that the health institutions fall under (INAO, 2005, 2007).

Communication and organisation

The study's findings indicate that the administrators' stance towards the Ministry is fairly negative, and that they feel there is a considerable distance between them and ministry officials. Furthermore, the administrators feel that there is even a lack of understanding of the circumstances in the institutions. This they feel can be gathered, for example, from the Ministry's responses to applications and the recourses suggested by the institutions but those often reveal little knowledge of actual situations. Executives even believe that one of the main stress-factors in a manager's job is the relations with the Ministry.

Findings further indicate that there is a lack of encouraging atmosphere and an understanding of the need for change. Consensus seems to be lacking on new emphases, such as measuring results. Frank dialogue and consultation between administrators and the Ministry on long-term policy planning is not prominent. All these negative components are, according to Drucker (1974), among key issues of communications. He stresses the principles of clear objectives and the promotion and process of maintaining motivation. To achieve this, broad participation is highly desirable, teamwork is preferable, and skilled, honest and that open dialogue is conducted.

As described in section 2.5, an extensive survey of the work environment of around 200 public officials was conducted in 2007 (Kristmundsson, 2007). The survey revealed some negative outcomes and weaknesses to the Ministry of Health. No comparable survey has been conducted since then, but as a result of the findings of this survey, the Ministry redressed some of their weaknesses. However, the findings of this particular study indicate, that a desirable success in that sense is yet to be achieved.

Strengths and weaknesses

In a manager's terms of reference his main tasks are defined, the approaches to take, and the resources a manager has to fulfil these tasks. A manager of a healthcare institution is meant to organise the operation, to have the responsibility of integrating different aspects of the organisation, and ensure that the service provided is cost effective and meets objectives. Evidently, the most vital resources of any healthcare institution are found in their human resources. The study's findings reveal that the roles and job descriptions in healthcare institutions are in some instances vague, and interviews indicate that this affects the operation and job satisfaction. There are also various reasons for the unclear definitions of roles, such as limited levels of operation, slack management, or old traditions and culture in the work place.

This is in line with both Rolfe (2011) and Mosadeghrad and Ferdosi (2013) who highlight how important it is for the employees to feel content with the working conditions and their roles. They argue with confidence that weaknesses in this area can affect success and the operation of the institution, not to mention job satisfaction

Additionally, the study found that managers believe that current budget appropriations to the institutions are a limiting factor, which considerably hinders the flexibility they need to provide for the compulsory services. This has led to the organisation of the operation being muddled, and progressively more tasks are being handled by fewer employees. It is thus a challenge for the manager to respond to difficult situations. Mintzberg and Gosling (2002) in their paper discuss preferable skills and abilities of managers to control changes in the environment and they emphasise that these are evident and important parts of the job.

Interviews further indicated that the participants all employ, to some extent, their theoretical knowledge on the job. As an example, the majority mentioned the need for crisis management in the operational difficulties of the previous years. However, this was despite situations being so difficult that it was hard to utilise constructive and theoretical approaches in management. It is the rule rather than the exception that the managers in their daily activities have to react to unforeseen internal as well as external challenges. In these circumstances they need to make instant decisions as Mintzberg has also frequently described in his research on active managers in different organisations (Mintzberg, 1975, 2009).

The organisation of healthcare services has been altered a great deal in these past years. Findings from the interviews with Ministry officials confirmed that this evolution is likely to continue and, moreover, that authorities plan to further reduce the number of independent healthcare institutions and create larger institutions instead. This will lead to increased demands on the education and skill of managers. Additionally, managers will need recognised resources to navigate the fluctuating environment of healthcare services (Axelsson, 1998).

There are multiple management theories and each one will fit a different circumstance, but these have much in common. However, chances are that one such theory, the Transformational Leadership Theory (Bass, 1990; Yukl, 1999) might suit the objectives that are being worked towards, combined with other methods. Important elements are active participation of staff and their share in the decision making. A feeling of ownership over ideas and a common vision are created when things work out well, and this also has positive effects on morale, such as both Meyer (2008) and Drucker (1974) highlight. Additionally, this reinforces staff in their work and empowers them to take more responsibility and show leadership in their careers. These methods have been applied at management level in healthcare with positive results (Rolfe, 2011).

Finally, this vision is actually close to the findings of the study and seems to fall in line with the expressed attitudes of the managers and executives. Additionally, the aforementioned approach might be optimal where a few smaller institutions have been merged into one geographically dispersed institution, in which service needs to be clearly defined and provided in accordance with the community and its needs.

7.2 Method discussion

In the qualitative research tradition, an empirical task begins by the researcher's intuitive perception or comprehension of what characterises the phenomenon he wants

to study. The reason can be a special interest in the field or a professional experience (Ruth, 1991) as was the case for the current work.

In preparing this study, the author looked carefully at the methods best suited to data collection. More than one alternative was evaluated and finally the form of semi-structured interview was chosen. Interviews were considered more appropriate rather than using a survey/questionnaire or interview focus groups. This is because individual interviews might provide more opportunities to ask for clarification and ask follow-up questions during the interview situation (Kvale and Brinkmann, 2009).

The interview is a vibrant form and demands that the interviewer is alert and knows with certainty what questions he wants to get answered. However, the risk in a weakly structured interview is that it can produce large amounts of non-relevant data. It is therefore necessary to be focused from the start. This is a part of the craft of qualitative research and it is obvious that an experienced researcher can more easily meet these challenges than an inexperienced one. In qualitative studies, the researcher is involved in the interaction taking place in the interview. The researcher is a co-creator of the text, and the researcher's preconceptions are also an important part of the process of interpretation (Graneheim and Lundmann, 2004)

The study was completed in the wake of a great upset that shook the society in late 2008, both in Iceland and worldwide as well. These circumstances might have had an impact on the general atmosphere among those that work in this area. Therefore, the negative effects that the economic difficulties created were evaluated, as was possible during the research. The author kept in mind Ruth's comment regarding the need to look at comments and statements in the context in which they are presented (Ruth 1991). Also it was natural to take this specifically into consideration in the interview situation and alongside the analysis of data as Kvale and Brinkmann (2009) emphasise as regards ethics and quality.

In regards to the credibility and validity of the findings, it should be considered how well the author is acquainted with the subject matter and the participants. This familiarity could affect the treatment of data, the analysis and the findings. The author tried to be mindful of this during the research process, and consequently limit his personal involvement in the interviews by setting aside his opinions and interpretations. According to Malterud (2001a), doing research on "colleagues" poses challenges for both the researcher and the participants. The question in this context is, if the participants have been reserved in expression or the opposite. Participants may have been more open in the interview and an external interviewer could have received other responses. Therefore it is important to work responsibly and in accordance with ethical rules. Extensive knowledge on the subject can be an advantage with respect to asking the right questions. The downside is that one's own pre-supposition can affect data collection and provide information bias. In this respect, the author tried to accept the participant's declarations with an open mind, as well, as generally try to station his own attitudes "within brackets" and approach the subject matter with good morality (Ruth, 1991).

8 CONCLUSION AND REFLECTIONS

The aim of this study was to shed light on managerial aspects regarding governance of healthcare in Iceland, the environment of managers of healthcare institutions, their bonds with immediate executives and Ministry officials, as well as to attempt to analyse the relative weaknesses and strengths in this field.

The study found both strengths and weaknesses in the communications between managers, executives, and the Ministry, but more weaknesses, though, in relation to communication with the Ministry. Even if the general attitude towards the Ministry is somewhat negative there is willingness to try to rectify the situation and set a clear communication structure.

There is considerable disparity between the experiences of the administrators in healthcare institutions on the one hand and the Ministry officials on the other. This disparity has to do with the policy the government believes it is following. Furthermore, this is something that the managers believe that is a great weakness that undermines their work. Therefore, it is desirable that the authorities analyse the reasons why there is such a disparity between the managers' experiences and understanding and the Ministry's emphases and visions for the future.

Findings further indicate the necessity to set some goals that work towards strengthening and structuring the communications between the Ministry and the institutions. This can be achieved by utilising items mentioned in the study regarding the optimisation of theoretical hypotheses, such as on Transformational Leadership or Strategic Management.

The study's findings made frequent mention of the manager's terms of reference and how managers were aware of their duties according to them. However, the findings also indicate that the Ministry repeatedly interferes with a manager's responsibilities and scope of work when it comes to individual matters. Therefore, it is pertinent to clarify the relevant procedures.

Finally, there is a reason to investigate further the repeated recommendations of the Icelandic National Audit Office (INAO) and the Ministry's position on utilising lawful sanctions towards administrators who presumably do not respect laws and regulations in the operation. Additionally, the Ministry officials stated that there have been instances which merited such sanctions, even if none had been resorted to. Therefore, it is important to examine the reasons behind this and see if unclear communications, possible flaws in appropriation of operational budget, execution of services, or the ambiguous messages from the Ministry to institutions, are at all to blame.

9 ACKNOWLEDGEMENTS

At this stage in a long and never ending learning process I would like to thank all of those who made this study into what it has turned out to be, i.e. participants, work colleagues, representatives of the Ministry of Welfare, and those who read the text and offered some valuable advice and guidance.

Especially, I would like to thank my supervisor, Dr. Helga Sól Ólafsdóttir, for her encouragement, motivation, and professional approach. The completion of this project has been rigorous and a constructive learning phase that doubtless will be personally enlightening for me in the future.

Furthermore I thank NHV administrators, teachers and staff for their priceless warmth, togetherness, and awareness through the years and I wish them all the best in a new arena, now when this Nordic educational institution, NHV closes its door for the last time in the end of the year.

Last, but not least, I thank my family for their patience and tolerance during the working periods, especially my loving wife for her great understanding and warmth throughout, as well as for constant encouragement, optimism and support.

During the preparation and final work on the project, both my parents passed away and with great kindness and affection, I dedicate this work to them.

10 REFERENCES

- Adair, J., Reed, P. (2004). *Not Bosses But Leaders*, Kogan Page Limited, London.
- Aðalsteinsson, G.D. (2010). “Starfsumhverfi hins opinbera, hlutverk stjórnenda og viðhorf starfsmanna”, [Operating environment of the public sector, executives’ role and attitude of staff]. *Stjórnámál og Stjórnsýsla, vef tímarit 2*, [Institute for Public Administration and Politics, University of Iceland, webmagazine 2]. Reykjavík, Háskóli Íslands, pp. 65-78.
- Andersen, P.T., Jensen, J.J. (2010). “Healthcare reform in Denmark”. *Scandinavian Journal of Public Health*, vol. 38, pp. 246-252.
- Ásgeirsdóttir, T.L. (2009). The Icelandic health care system. In: *Nordic Health care Systems, Recent Reforms and Current Policy Challenges*. Magnussen J., Vrangbæk K., Saltman R.B. (eds.) Open University Press, Berkshire, (p. 316-330).
- Axelsson, R. (2000). “The organizational pendulum: Healthcare management in Sweden 1865 – 1998”, *Scandinavian Journal of Public Health*, vol. 28(1), pp. 47-53.
- Axelsson, R. (1998). “Towards an Evidence Based Healthcare Management”, *International Journal of Health Planning and Management*, vol. 13, pp. 307-317.
- Baker, G.R. (2003). “Healthcare Managers in the Complex World of Healthcare”, *Frontiers of Health Services Management*, vol. 18(2), pp. 23-32.
- Bass, M.B. (1990). *Bass and Stogdill’s Handbook of Leadership, Theory, research and Managerial Application*, (3rd ed.) The Free Press, New York.
- Bryman, A. (2004). “Qualitative research on leadership: A critical but appreciative review”, *The Leadership Quarterly*, vol. 15, pp. 729-769.
- Bryman, A., Stephens, M., Campo, C. (1996). “The importance of Context: Qualitative Research and the Study of Leadership”, *The Leadership Quarterly*, vol. 7(3), pp. 353-370.
- Cole, F.L. (1988). “Content Analysis: Process and Application”, *Clinical Nurse Specialist*, vol. 2, pp. 53-57.
- Covey, S.R. (1996). Three Roles of Leader in the New Paradigm. In: *The Leader of the Future*. Hesselbein, F., Goldsmith, M., Beckhard, R, (eds.), Drucker Foundation Series: Jossey-Bass, A Wiley Company, San Francisco, (pp. 149-160).
- Daft, L.R., Marcic, D. (2001). *Understanding Management*, Harcourt College Publishers, Orlando.
- Drucker, P.F. (1974). *Management: Tasks, Responsibilities, Practices*, Harper Collins, New York.

Drucker, P.F. (1982). *Managerial Organization*, Heinemann Professional Publishing Ltd. London.

Edwards, N. (ed.) (2003). “Doctors and managers: a problem without a solution?” *British Medical Journal*, vol. 326, pp. 609-610.

Einarsson, I. (1995). *Mótun framtíðarstefnu á sviði forvarna og heilsueflingar* [Shaping policies for the future in the field of prevention and health promotion], Reykjavík; Ministry of Health and social Security.

Elo, S., Kyngäs, H. (2007). “The qualitative content analysis process”, *Journal of Advanced Nursing*, vol. 62 (1), pp. 107-115.

Goethals, G.R., Sorenson, G.J. (eds.) (2004). *Encyclopedia of Leadership*, Thousand Oaks: Sage Publications, California.

Graneheim, U.H., Lundman, B. (2004). “Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness”, *Nurse Education today*, vol. 24, pp. 1277-1288.

Halldórsson, M. (2003). *Healthcare Systems in Transition*, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, Copenhagen.

Holmberg, I., Tyrstrup M. (2010). “Well then – What now? An everyday approach to managerial leadership”, *Leadership*, vol. 6, pp. 353-372.

Hood, C. (1995). “The New Public Management” in the 1980s: Variation on a theme, *Accounting, Organizations and Society*, vol. 20, pp. 93-109.

Hsieh, H.F., Shannon, S.E. (2005). “Three Approaches to Qualitative Content Analysis”, *Qualitative Health Research*, vol. 15, pp. 1277-1288.

INAO, The Icelandic National Audit Office (2005). *Greinargerð um framkvæmd fjárlaga 2004* [Report on the execution of the Government Budget in 2004], Reykjavík: Ríkisendurskoðun.

INAO, The Icelandic National Audit Office (2007). *Framkvæmd fjárlaga árið 2006*, [Implementation of Government Budget in 2006], Reykjavík: Ríkisendurskoðun.

INAO, The Icelandic National Audit Office (2008). *Framkvæmd fjárlaga árið 2007 og ársáætlanir 2008*, [Implementation of Government Budget in 2007 and 2008 Annual Plans], Reykjavík: Ríkisendurskoðun.

INAO, The Icelandic National Audit Office (2009). *Framkvæmd fjárlaga 2009, janúar til ágúst – skýrsla til Alþingis* [Implementation of Government Budget in 2009 January to August - a report to the Parliament], Reykjavík: Ríkisendurskoðun.

INAO, The Icelandic National Audit Office (2012). *Skýrsla um eftirfylgni: Heilbrigðisstofnun Austurlands (2009)* [Report on the follow-up: Heilbrigðisstofnun Austurlands (2009)], Reykjavík: Ríkisendurskoðun.

INAO, The Icelandic National Audit Office (2013). *Reiknilíkan heilbrigðisstofnana á landsbyggðinni – skýrsla til Alþingis* [Calculation model of healthcare facilities in the regions – a report to the Parliament], Reykjavík: Ríkisendurskoðun.

INAO, The Icelandic National Audit Office (1996). *Samantekt á stjórnýsluendurskoðun hjá sjö sjúkrahúsum* [A summary of the audits of seven hospitals], Reykjavík: Ríkisendurskoðun.

Kjekshus, L.E. (2009). Changing demands for institutional management. In: *Nordic Healthcare Systems, Recent Reforms and Current Policy Challenges*. Magnussen J., Vrangbæk K., Saltman R.B. (eds.) Open University Press, Berkshire, (p. 274-293).

Kotter, J.P. (1988). *The Leadership Factor*, The Free Press, Collier Macmillan Publishers, London.

Kreitner, R. (2006). *Management, ninth edition*. Houghton Mifflin Company, New York.

Kristiansen, I.S., Pedersen, K.M. (2000). “Helsevesenet i de nordiske land – er likhetene større enn ulikhetene?” , *Tidsskrift for Den norske legeforening*, nr.17.

Kristmundsson, Ó.H. (2007). *Stjórnun og starfsmannamál ríkisstofnana – niðurstöður könnunar á viðhorfum forstöðumanna, 1. hluti*, [Management and human resources of public institutions - results of a survey on the attitudes of directors, part 1], Reykjavík: Ministry of Finance and Economical Affairs.

Kvale, S., Brinkmann, S. (2009). *Den kvalitative forskningsintervjun*, Studentlitteratur AB, Lund.

Lameire, N., Joffe, P., Wiedemann, M. (1999). “Healthcare systems – an international review: an overview”, *Nephrology Dialysis Transplantation*, vol. 14 (6), pp. 3-9.

Malterud, K. (2001a). “The art and science of clinical knowledge: evidence beyond measures and numbers”, *The Lancet*, vol. 358, pp. 397-400.

Malterud, K. (2001b). “Qualitative research: standards, challenges, and guidelines”, *The Lancet*, vol. 358, pp. 483-488.

Martinussen, P.E., Magnussen, J. (2009). Health care reform: the Nordic experience. In: *Nordic Health care Systems, Recent Reforms and Current Policy Challenges*. Magnussen J., Vrangbæk K., Saltman R.B. (eds.) Open University Press, Berkshire, (p. 21-52).

Meyer, P.J., Slechta, R. (2008). *The Total Leader, Effective strategic leadership*, The Meyer Resource Group Inc. USA.

Ministry of Finance and Economic Affairs (1996a). *Stefna um nýskipan í ríkisrekstri* [Policy on innovation in governmental operations], Reykjavík: Fjármálaráðuneyti.

Ministry of Finance and Economic Affairs (1996b). *The Government Employees Act, No. 70/1996*. Available in English from: <http://eng.fjarmalaraduneyti.is/legislation/nr/561> [accessed August 2014].

Ministry of Health and Social Security (2005). *Terms of reference*. Available in Icelandic from: http://www.velferdarraduneyti.is/media/Stofnanir/Erindisbref_framkvamdastjora_heilbrigdisstofnana.pdf, [accessed August 2014].

Ministry of Health and Social Security (2007a). *Health Service Act, No. 40/2007*. Available in English from: <http://eng.velferdarraduneyti.is/acts-of-Parliament/nr/20098>, [accessed August 2014].

Ministry of Health and Social Security. (2007b). *Reglugerð um heilbrigðisumdæmi nr. 785/785*, [Regulation on healthcare regions no. 785/2007], Reykjavik: Ministry of Health and Social Security.

Ministry of Health and Social Security. (2008). *Heilsustefna 2008-2011 – heilsa er allra hagr*, [The Icelandic Health Strategy 2008 – 2011 - health is everyone's concern], Reykjavik: Ministry of Health and Social Security.

Ministry of Welfare (2012) Welfare Policy. *Velferðarstefna. Heilbrigðisáætlun til ársins 2020, drög*, [National Health Plan to 2020, draft], Reykjavik: Ministry of Welfare.

Mintzberg H., Gosling, J. (2002). “Educating Managers Beyond Borders”, *Academy of Management Learning and Education*, vol. 1, pp. 64-76.

Mintzberg, H. (1975). “The manager’s job: folklore and fact”, *Harvard Business Review*, vol. 53(4), pp. 49-61.

Mintzberg, H. (1993). *Structure in Fives, Designing Effective organizations*, Prentice Hall, Upper Saddle River, N.J.

Mintzberg, H. (2009). *Managing*, Barret-Koehler Publishers, Inc., San Francisco.

Mosadeghrad, A.M., Ferdosi, M. (2013). “Leadership, Job Satisfaction and Organizational Commitment in Healthcare Sector: Proposing and Testing a Model”, *Mater Sociomed*, vol. 25 (2), pp. 121 – 126.

Northouse, P.G. (2007). *Leadership, theory and practice*, Thousand Oaks: SAGE Publications.

Ólafsson, G.A. (2013). *Ísländska hálsovárðsystem; Struktur, prioritering och finansiering hálsovården – Finns ett liv efter finanskrisen?* Lecture on the Icelandic healthcare system. Nordic School of Public Health, Nov. 2013.

Oppedal, S., Stigen, I.M. (eds.) (2005). *Helse-Norge i støpeskjeen. Søkelys på sykehusreformen*, Fagbokforlaget, Bergen.

Prenestini, A., Lega, F. (2013). "Do senior Management Cultures Affect Performance, Evidence From Italian Public Healthcare Organizations", *Journal of Healthcare Management*, vol. 58:5, pp. 336-352.

Rolfe, P. (2011). "Transformational Leadership Theory: What Every Leader Needs to Know", *Nurse Leader*, vol. 9(2), pp.54-57.

Ruth, J.E. (1991). «Reliabilitets- och validitetsfrågan i kvantitativ respektive kvalitativ Forskningstradition», *Gerontologia*, vol. 5 (4), pp. 277-290.

Savoie, D.J. (2003). *Breaking the Bargain: Public Servants, Ministers and Parliament*, University of Toronto Press, Toronto.

Sayles, L.R., Strauss, G. (1966). *Human Behavior in Organizations*, Prentice-Hall, Inc., New Jersey.

Schein, E.H. (1996). "Three Cultures of Management: The Key to Organizational Learning", *Sloan Management Review*, vol. 38:1, pp. 9-20.

Schulz, R., Johnson, A.C. (1983). *Management of Hospitals*, McGraw-Hill Book Company, New York.

Shortell, S.M., Kaluzny, A.D. (2006). *Healthcare Management – Organization Design and Behavior*, Thomson Delmar Learning, USA.

Skogstad, A., Einarsen, S. (1999). "The importance of a change-centred leadership style in four organized cultures", *Scandinavian Journal of Management*, vol. 15, pp. 289-306.

Steinþórsson, R. (2003b). "Lýsing á stefnu og stefnumótunarvinnu", [Description of policy and strategic planning], *University Press, Iceland*, pp. 317-329, Reykjavík: Háskóli Íslands.

Steinþórsson, R.S. (2003a). "Stefnumiðuð stjórnun: Fimm greiningarlíkön", [Strategic Management: Five analytical models], *Magazine on business and economics, University of Iceland*, Reykjavik: Háskóli Íslands.

Strebel, P. (1996). "Why Do employees Resist Change?", *Harvard Business Review*, vol. 74(3), pp. 85-92.

Websites, examples of media coverage in 3 Nordic countries regarding termination of hospital managers. Accessed from:

<http://www.dn.no/nyheter/2011/06/06/siri-hatlen-gar-av-som-sykehussjef>
<http://www.aftenposten.no/nyheter/iriks/Ahus-direktor-Hulda-Gunnlaugsdottir-gar-av-pa-dagen-7340159.html>
<http://www.kl.dk/menu/Suzanne-Aaholm-fratrader-sin-stilling-id123772/>
<http://dknyt.dk/sider/artikel.php?id=46716#.U-zvf29oH3h>
<http://www.dagensmedicin.se/jobb/ledarskap/sigbjorn-olofsson-far-sparken/>
<http://www.sydsvenskan.se/sverige/sjukhuschefen-i-ystad-sparkas/>

[accessed August 2014]

WHO, World Health Organization (2004a). *Management, Leadership and Partnership for District Health*, WHO, Brazzaville, Africa.

WHO, World Health Organization (2004b). *Standards for Health Promotion in Hospitals*, WHO European Office for Integrated Healthcare Service, Barcelona.

WHO, World Health Organization (2007). *Worker's health: global plan of action*, WHO – sixtieth World Health Assembly.

WHO, World Health Organization (2009). *Milestones in Health Promotion, Statements from Global Conferences*, WHO, Switzerland.

WHO, World Health Organization (2012). *Health 2020: a European policy framework supporting action across government and society for health and well-being*, WHO, regional Committee for Europe, Copenhagen.

Wren, D.A., Bedeian, A.G. (2009). *The Evolution of Management Thought*, John Wiley & Sons, Inc., Hoboken, NJ.

Yukl, G. (1999). "An Evaluation of Conceptual Weaknesses in Transformational and Charismatic Leadership Theories", *Leadership Quarterly*, vol. 10(2), pp. 285-305.

Akranesi, 16th of January, 2014

.....
.....
.....

Dear XXXXXXXX, I refer to our mail earlier and thank you for the positive response to my request to be allowed to do an interview with you for a project I'm working on. I would formally like on this stage to give a brief overview of the project.

As pointed out in our conversation I am working on a final project for MPH degree at the Nordic School of Public Health in Gothenburg which I plan to finish by the end of 2014 if everything goes as planned. The project focuses on the role of the manager, particularly the occupation CEO of healthcare institutions, the various roles that the manager is required to comply and focus areas of the job, according to letter of appointment, job descriptions and frames of law. It will be sought to shed light on the many factors that affect performance, external agents, influences, managerial styles, communication and manifestation of this in practice.

In the interview situation it will be focused on the participant's own expression in relation to experience from the field of managerial work in Icelandic healthcare and try to look at the overall context of the matter. An integrated interview framework will be followed in all cases and there is no reason to introduce the questionnaire in detail in advance as the subject matter is familiar and as natural to allow the discussion to evolve as appropriate.

My project is a qualitative research and I plan to talk to 10 executives at three levels of healthcare service. I assume that the interview will take approximately 50-60 minutes and I will rely on audio recording, the discharge and interpretation of results.

Complete anonymity and confidentiality will be respected and stressed that it will not be possible to trace comments or information presented to any of the participants in the study.

I also want to emphasize that you are fully entitled and free to cancel your participation in the study at any stage if you so choose.

However, I am very grateful to you for showing me the confidence to talk to me about that stuff that I hope will eventually lead to a greater understanding of the demanding and challenging operating environment of management in this this fundamental community service,

with friendly greetings,

Guðjón S. Brjánsson
gudjon.brjansson@hve.is

Interview – interview guide

(job title and working experience)

Manager's practice

- Definition
- Laws, administrative regulations and the terms of reference describes the tasks of healthcare managers. In your opinion, to what extent are the actual tasks, responsibilities and situations Director relevant to this?
- What is your opinion on the post of the manager, the ability to enforce administrative decisions according to law and the terms of reference?
- What are actually the most important tasks of the manager?
- To what extent has the manager the tools and the opportunity to reach around, deal with and solve the most important tasks?
- Does the manager activate any structured academic management theory in his work and communicating with colleagues/co-workers?
- Examples of theories / methods?
- If not, do you think it is desirable?
- What is the reason for not following specific theories?
- Do you think that there are any obstacles in the way of this?
- How well do you think the roles and functions of executives are defined?
- How is this implemented?
- Do you ever as an executive experience you self as stuck in between, as between a rock and a hard place?
- Does the system or structure of it in in any cases cause frictions or inefficiency due to unclear definitions or strategy planning?
- Do you ever sense difficulties in communication at management level in the field of healthcare because the roles are not clear, professionally or financially?
- Is there anything that could be improved?
- Do you think you succeed in meeting the expectations of government and executives in terms of managerial work and communication?
- Do you think there is a difference in your own opinion and the opinion of colleagues about your role as a manager of the organization?
- Managers are sometimes criticized for the lack of controls in the management of healthcare institutions, especially in terms of budget. Do you agree with this?
- In your opinion, are there ways to improve?
- After your impression, are managers fully aware of what is expected of them?
- Are the requirements for managers / executives of healthcare institutions unrealistic or incompatible under any circumstances?
- How do you think your work, procedures and priorities are consistent with the needs of the organization?

- Is there anything quite unique about role of the manager of healthcare institutions that makes it different from other posts of managers, either in public service or at general labor market?

Operational environment of the manager / colleagues / Ministry

- Is the knowledge and experience of the manager utilized to deal with the most important tasks?
- What expectations and beliefs / attitudes do colleagues have about the role of the manager according to your opinion?
- How do expectations and pressures from the Community affect in the daily practice?
- Expectations of higher authority and manifestations of it. Is this in accordance with the institution's needs?
- How is the reality in the light of the past?
- Do you in fact think that there is similar understanding of the role and expectations of the manager?
- If the outcome is different, in what areas is it most prominent?

Communication with higher authority formal / informal - executives

- Do you think you are in a position to meet expectations of government and co-workers?
- The message and ministry expectations or is there need to clear up?
- Is there a common understanding of other executives and government in this respect, based on your understanding?
- Do you think that there is an understanding at the level of the Ministry of the situation and working environment of managers and the demands they believe they need to answer?
- What indicates the laws, regulations and terms of reference - is consistency at all levels?
- What is the empirical evidence?

Improvements

- What are the weaknesses and strengths of the current system as it is implemented in reality?
- How do you see improvement in this sector?
- In what areas are most needed to strengthen the work of the manager towards the Ministry?

What qualities does a manager need to be equipped with to be successful?

- 1 In your own opinion,
- 2 in the opinion of colleagues,
- 3 in the opinion of senior management/authorities.

