How privatization and corporatization affect healthcare employees' work climate, work attitudes and ill-health

Implications of social status

Helena Falkenberg

©Helena Falkenberg, Stockholm 2010

ISBN 978-91-7447-019-2

Printed in Sweden by US-AB, Stockholm 2010

Distributor: Department of Psychology, Stockholm University

Cover photo: Clayton Thornton. Waterfall in Letchworth
Park, NY.

Abstract

Political liberalization and increased public costs have placed new demands on the Swedish public sector. Two ways of meeting these novel requirements have been to corporatize and privatize organizations. With these two organizational changes, however, comes a risk of increased insecurity and higher demands on employees; the ability to handle these changes is likely dependent on their social status within an organization. The general aim of the thesis is to contribute to the understanding of how corporatization and privatization might affect employees' work climate, work attitudes and ill-health. Special importance is placed on whether outcomes may differ depending on the employees' social status in the form of hierarchic level and gender. Questionnaire data from Swedish acute care hospitals were used in three empirical studies. Study I showed that physicians at corporatized and privatized hospitals reported more positive experiences of their work climate compared with physicians at a public administration hospital. Study II showed that privatization had more negative ramifications for a middle hierarchic level (i.e., registered nurses) who reported deterioration of work attitudes, while there were no major consequences for employees at high (physicians) or low (assistant nurses) hierarchic levels. Study III found that although the work situation for women and men physicians were somewhat comparable (i.e., the same occupation, the same organization), all of the differences that remained between the genders were to the detriment of women. The results of this thesis suggest that corporatizations and privatizations do not necessarily imply negative consequence for employees. However, the consequences appear to differ between groups with different social status. Employees whose immediate work situation is affected but who do not have sufficient resources to handle the requirements associated with an organizational change may perceive the most negative consequences.

Keywords: Corporatization, privatization, organizational change, ownership, healthcare employees, acute care hospitals, physicians, social status, hierarchic level, gender, work climate, work attitudes, ill-health.

Acknowledgements

As the work for this thesis nears the end, my thoughts go out to all who have supported and helped me along the way. I am truly fortunate to have had such good companions while working through the funniest job that I could imagine.

To begin with, many thanks to the Swedish Council for Working Life and Social Research (FAS), the Stockholm County Council, and the Department of Psychology, Stockholm University who contributed to the financial support that made the research presented in this thesis possible.

Above all, I am deeply grateful to my two supervisors, Professor Magnus Sverke and Associate Professor Katharina Näswall, who have supported me in every way possible since I first came to the Division of Work and Organizational Psychology. Thanks for all of your patience, endless support and admirable knowledge.

I am also grateful to Magnus Sverke (again) and Johnny Hellgren, who first asked me to work with collecting data and then to continue to work on the “hospital project”. Thank you also Caroline Stjernström, who recommended me for the job. My very first impression of academic work was formed by the warm welcome from the people at the Division of Work and Organizational Psychology and I am very grateful to have had the chance to work in such an inspiring atmosphere. Thanks to all of you who worked in the Division when I started in the autumn 2002 and all that have come to the department since, including Stefan Annell, Gunnar Aronsson, Wanja Astvik, Stephan Baraldi, Eva Bejerot, Claudia Bernhard-Oettel, Erik Berntson, Victoria Blom, Kristina Danilov, Ann Fridner, Anders Eriksson, Mats Gautam, Ulla Gautam, Marie Gustafsson, Sara Göransson, Niklas Hansen, Johnny Hellgren, Lars Häsänen, Gunn Johansson, Petra Lindfors, Lena Låstad, Malin Mattsson, Eva Mauritzson-Sandberg, Marika Melin, Christin Mellner, Ann Richter, Sofia Sjöberg, Teresia Stråberg, Ulrika von Thiele Schwartz, Ingemar Torbiörn, Tom-Stian Vetting and Cornelia Wulff. Great thanks also to other members of the Department of Psychology for help with various matters such as administration and computer problems, as well as great conversations during lunch breaks. Warm thanks also go out to Professor Henry Montgomery, who has always had an encouraging word for me.

Special thanks to my roommates throughout the years: Teresia Stråberg, my very good friend with whom I have shared so many joys and worries; Stephan Baraldi, for a short but fun time together in the “sea” and for further cooperation since; and Anne Richter, for a range of valuable advice, from cooking to LISREL.

I would also like to thank Professor Ingemar Torbiörn, Associate Professor Tuija Muhonen and Associate Professor Petra Lindfors for valuable comments on the thesis. Thanks also to Josefin Särnholm and Jean-Paul Small for their translation and language check of the manuscript, and Anders Sjöberg whose co-authorship in Study II was very valuable.

My deepest appreciation and warmest thoughts go out to those who have supported me the whole way: to my mum Ulrika, my dad Henrik and brother Erik, who have always been my great security and comfort and inspired me to learn new things. Thanks also to my brother Erik’s family: to Carina, Emma and Filip and all of my wonderful relatives and friends that have always been by my side. And, of course, a big thank you to my “own” family: to my great love in life, Sebastian, to my big happiness Miranda (soon “the book” will be ready and I think you will like that) and to our unborn baby who, with intensive kicks, frequently reminds me that there are things in life other than thesis work.

Thanks to you all!

Helena Falkenberg
Stockholm, February 2010

List of studies

- I Hellgren, J., Sverke, M., Falkenberg, H., & Baraldi, S. (2005). Physicians' work climate at three hospitals under different types of ownership. In C. Korunka & P. Hoffmann (Eds.), *Change and Quality in Human Service Work*, pp. 47-65. Munich: Rainer Hampp.

Reproduced with permission from © Rainer Hampp Verlag.

- II Falkenberg, H., Näswall, K., Sverke, M., & Sjöberg, A. (2009). How are employees at different levels affected by privatization? A longitudinal study of two Swedish hospitals. *Journal of Occupational and Organizational Psychology*, 82, 45-65.

Reproduced with permission from Journal of Occupational and Organizational Psychology © The British Psychological Society (2009).

- III Falkenberg, H., Näswall, K., & Sverke, M. (submitted). Gender differences in physicians' psychological climate, work-related attitudes and health.

Contents

Introduction	1
General aim.....	4
Organizational change.....	7
Why do organizations change?	8
Driving forces for organizational change.....	10
Internal driving forces.....	10
External driving forces	11
Corporatization and privatization.....	12
What is corporatization and privatization?	13
Consequences for employees	14
Social status	17
Social status and its consequences	17
Hierarchic level as a marker for social status in the context of organizational change.....	19
Gender as a marker of social status in an organizational change context ...	21
Method	24
Background to the changes in acute care hospitals.....	24
The hospitals in the thesis	25
The privatized St. Göran's Hospital.....	25
Corporatized Danderyd's Hospital	26
The public administration-run Södertälje Hospital	26
Samples	27
Sample for Study I.....	29
Sample for Study II	29
Sample for Study III.....	30
Measures.....	31
Summary of studies.....	37
Study I: Physicians' work climate at three hospitals under different types of ownership	37
Background.....	37
Aim	37
Method.....	37

Results	38
Conclusion	38
Study II: How are employees at different levels affected by privatization? A longitudinal study of two Swedish hospitals	38
Background	38
Aim	39
Method	39
Results	39
Conclusion	40
Study III: Gender differences in physicians' psychological climate, work- related attitudes and health	40
Background	40
Aim	41
Method	41
Results	41
Conclusion	42
Discussion	43
Difference in ownership and the consequences for employees	43
The importance of social status in the form of hierarchic level	44
The importance of social status in the form of gender	47
Methodological considerations	49
Theoretical implications	53
Corporatization and privatization	53
The importance of social status	54
Conclusion	57
References	59

Introduction

Organizational changes have taken place as long as people have organized themselves and changes will persist as long as humans continue to coordinate their efforts (cf. W. W. Burke, 2002). We live in an era of diversity where technological developments and globalization have spawned large upheaval for societies, organizations and individuals and have lead to increased demands for efficiency and competition (R. J. Burke & Cooper, 2000). Organizations have tried to meet these societal changes by adapting and these adaptations have produced many different organizational changes: downsizing, consolidation, buy-outs and outsourcing, for example (Quick, Gowing, & Kraft, 1998). These developments in society, together with political liberalization and increased costs within the public sector, have brought about new requirements for public organizations (Blomqvist & Rothstein, 2000; Megginson & Netter, 2001; von Otter, 2003). Two ways of meeting these demands are to corporatize and privatize organizations. Corporatization occurs when a public organization converts into a stock company, but the company is still mainly owned by the public (Aidemark, 2005) and is usually non-profit driven. On the other hand, privatization refers to a public organization that is sold, completely or partly, to a private agent (Ramamurti, 2000). Privatization can concern the financing, production or regulation of a specific activity (Donahue, 1989; Lundqvist, 1991).

These changes have been investigated from different perspectives, such as the economical consequences privatization have on organizations (Bishop, Kay, & Mayer, 1994; Megginson, 2007; Megginson & Netter, 2001), the democratic consequences of corporatization and privatization (Blomqvist, 2005; Blomqvist & Rothstein, 2000), characteristics of public and privatized organizations (Bozeman 1987; Bozeman & Bretschneider, 1994; Perry & Rainey, 1988) and the legal effects privatization has on citizens (Landelius, 2006). From a psychological perspective, the consequences of corporatization and privatization, where employees' situation is the focus, have been examined in only a few studies and the results of these studies are somewhat contradictory. Previous research has identified both positive and negative consequences of corporatization and privatization for employees' work climate, work related attitudes and health (Aidemark, 2004; Cunha, 2000; Cunha & Cooper, 2002; Falkenberg, Sverke, Hellgren, & Näswall, 2004; Ferrie et al., 2001; A. Nelson, Cooper, & Jackson, 1995; Öhrming & Sverke, 2001; Struwig & van Scheers, 2004; Sverke, Hellgren, & Öhrming,

1999; Wallenberg, 2001), and it is unclear why these consequences vary. One possible explanation is that different categories of workers are differently affected by organizational change. More in-depth knowledge is therefore needed regarding why consequences can appear in a specific way and, what consequences corporatization and privatization might have for different groups of employees (Egan, Petticrew, Ogilvie, Hamilton, & Drever, 2007).

The advantages and disadvantages of increased competition and market-driven elements within the healthcare sector have been extensively debated both in Sweden and internationally for years (Chiesa, 2005; Dahlgren, 2003; Earle, 2009; Harrington & Pollock, 1998; Jordahl, 2006; Rosenberg, 1995; Serghis, 1998; Söderström & Lundbäck, 2001). The discussions have primarily concerned what roles public and private caregivers should have and to what extent profit-driven companies should be encouraged or hindered to act within the healthcare market. Political and economic forces have been driving development that has occasionally encouraged and at other times hindered privatization and corporatization. Healthcare is a personnel-intense activity, and the way employees receive patients and their relatives constitutes an integral segment of the quality of care (Aiken, Sloane, & Sochalski, 1998). The question of how the employees, who are on the frontlines of healthcare service, are affected has not been given very much attention. A positive work climate is assumed to be important in order for patients to receive good care. The work climate within healthcare is consequently not only important for the large group of people working within the healthcare sector but also for patients and their relatives. Further ascertaining how changes, such as corporatization and privatization, affect healthcare workers and if there are groups that are particularly vulnerable in these kinds of changes seems relevant and pressing. Processes within complex phenomena, such as changes within organizations, are difficult to predict and direct (Brunsson & Olsen, 1993). In the end, it depends on the employees if changes will be carried through with the desired effect (W. W. Burke, 2002). Therefore, knowledge about the consequences of corporatization and privatization is important not only from the employees' perspective, but also for the management staff who are responsible for implementing those kinds of organizational changes. As such, there are many interested parties that can benefit from knowing more about the conceivable consequences of corporatization and privatization for employees, especially since these forms of organizational changes most probably will continue to take place in Sweden and other countries in the near future.

Privatization and corporatization have been described as potentially very stressful events for the employed—events that imply extensive uncertainty about the future (A. Nelson et al., 1995; Öhrming & Sverke, 2001; Rosenberg, 1995). This dissertation presupposes that privatization and corporatization are changes that, like other organizational changes, can

present increased uncertainty. This uncertainty may affect the work climate and lead to more negative work related attitudes and decreased health (Bordia, Hunt, Paulsen, Tourish, & DiFonzo, 2004; Paulsen et al., 2005). Nevertheless, the repercussions of changes can look different within the same organization. Previous research has shown that access to different types of resources that facilitate participation and control are positive for how the work situation is experienced (Hackman & Oldham, 1976; Heller, Pusić, Strauss, & Wilpert, 1998). Individuals perceiving that they can control a situation that puts new demands on them experience the situation as less threatening (Lazarus & Folkman, 1984). In line with this reasoning, perceptions of control have shown to be able to reduce uncertainty and stress experiences (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001; Karasek & Theorell, 1990). Since organizations are inherently hierarchic, access to resources are not evenly distributed and will vary with employment social status (Henry, 2005). What constitutes social status in a certain context can vary, but this thesis focuses on two status factors, namely hierarchic level and gender¹.

Status in the forms of hierarchic level and gender generally has a fundamental influence on people's life, but may be especially important regarding changes, suggesting that personnel may have to mobilize resources to meet new demands. In the context of organizational changes, hierarchic level has been investigated to some extent (Armstrong-Stassen, 1998; Swanson & Power, 2001). It has been proposed that those with high hierarchic level are in a better position to handle organizational changes than those who are employed on a lower hierarchic level (Olson & Tetrick, 1988). While the previous description may not be unequivocal, another view examines the prospect of those with a high hierarchic level bearing extensive responsibility to carry out the change, and that the higher level of control and more influence their status implies are not enough to counteract the demands that follow the change (Martin, Jones, & Callan, 2006). Another possibility is that those employed on a lower hierarchic level are not particularly affected by a change and therefore do not experience it as a big threat (Swanson & Power, 2001; Tienari, 1999). The importance of status in the form of hierarchic level and what effect it has during a change has not yet been clarified.

Even though there is substantial evidence that women and men have different social status (Pratto & Walker, 2004; Ridgeway & Bourg, 2004; Rothman, 2005), there is a tendency to disregard gender as a status factor in organizational contexts (Acker, 1990). The association between gender and status is obvious when it comes to the labor market where women are often found working at lower positions, while leading positions often are held by

¹ The term sex has traditionally been used to categorize women and men from their biological sex, while the term gender has been used to refer to socially constructed aspects of females and males (Alvesson & Billing, 1997). In this thesis, the point of departure is that these terms overlap and the word gender is used to separate women into one group and men into another.

men (Eurostat, 2008). Women are also overrepresented in the public sector, where salaries tend to be lower than within the private sector (Statistics Sweden, 2007). These differences in working conditions have been proposed as possible causes for women often reporting more health related concerns than men (McDonough & Walters, 2001). Nevertheless, it is less clear how the differences in the relation between working conditions and well-being emerge when women and men work within the same sector and on the same hierarchic level. Some research suggests that there should not be any differences in work-related variables or health when women and men at the same level are studied (Greenglass, 1995). This has been confirmed in some studies (Torkelson & Muhonen, 2003) and contradicted in others (Frankenhaeuser et al., 1989; Lundberg & Frankenhaeuser, 1999; Torkelson, Muhonen, & Peiró, 2007). A possible difference in status is especially relevant in connection to an organizational change since change calls for handling uncertainty, which is facilitated by access to resources. If women have lower status than men, even when women and men work on the same level, it would imply that the genders have different possibilities to handle the demands in an organizational change. The difference in these possibilities may also imply that the consequences of a change could be different for women and men. Consequently, it may not be sufficient to simply consider what hierarchic level an employee has at the time of an organizational change but also to take status in the form of gender into consideration in order to better understand the consequences for the employee. There have been studies comparing women and men working on the same level without taking organizational change into consideration (Emslie, Hunt, & Macintyre, 1999; Liu, Spector, & Shi, 2008; Lundberg & Frankenhaeuser, 1999; Torkelson et al., 2007; Torkelson & Muhonen, 2003) and there are studies on how organizational change generally affects women and men that do not consider the employee's position (Collins, 2005; Karambayya, 1998; Tienari, 1999). However, the accumulated knowledge is very limited when it comes to potential consequences of organizational change for women and men working at the same hierarchic level.

General aim

The general aim of this thesis is to contribute to the understanding of how two forms of organizational change—corporatization and privatization—can affect employees. This thesis examines healthcare employees' work climate, work-related attitudes and ill-health in Swedish acute care hospitals that have undergone privatization and corporatization, or remained as a public administration-run unit. In order to understand potential group differences, a special importance is placed on whether such outcomes may differ depending on the employees' social status in the form of hierarchic level and gender.

In order to fulfill this aim, this thesis consists of three studies that highlight different aspects of the general aim from a healthcare context. Figure 1 describes the studies' mutual relations and how these could be traced to environmental factors that can be considered in order to determine the pressures of organizational change. As is shown in Figure 1, this thesis derives from the assumption that what takes place in society affects organizations. If societal changes are great enough, organizations must also change in order to adapt. Another assumption is that the initiative to change also can come from within organizations, either as an effect of societal change or independent of these changes. Thus, external and/or internal factors are assumed to lead to organizational changes and this thesis focuses on two particular changes: corporatization and privatization.

Regarding the individual, this thesis presumes that human behavior depends on the interaction between an actual situation and how individuals interpret that situation based on their own experience (cf. Ekehammar, 1974; James & Sells, 1981; D. Magnusson, 1981). An individual's interpretation of a situation, during an organizational change, is assumed to influence the individual's reaction to the change when it comes to work climate, work attitudes and health.

The objective of the first study was to describe what consequences corporatization and privatization can have for the work climate for a specific occupation (physicians). In the study, the work climate for physicians working in three acute care hospitals—one that had become a public stock company, one privatized hospital and one that had remained publicly administrated—were compared.

The objective of the second study was both to examine how healthcare employees are affected by privatization and to enhance the understanding of what privatization can imply for employees with different social status. How work related attitudes and ill-health changed for different hierarchic levels (physicians, registered nurses and assistant nurses) in connection to the privatization of an acute care hospital was analyzed. The results were compared with an administrative-run acute care hospital.

The objective of the third study was to examine if work climate, work related attitudes and ill-health differed between women and men who worked at the same occupation (physicians) and in the same acute care hospital after a corporatization. Furthermore, an investigation was conducted on whether the work climate was perceived in different ways by women and men, if the levels of psychological climate differed between women and men, and in addition, what factors in the work climate were important for women and men's work related attitudes and ill-health.

Figure 1. Conceptual model of the fundamental issues included in the thesis. The dashed squares and arrows represent factors and relations that are not empirically studied in the present thesis. The Roman numerals represent the three studies featured in the thesis.

Organizational change

Despite humanity's long history of organizing and change, the study of these changes is relatively new as the organization of labor, as we know of it today, first started with the industrial revolution. Frederick Taylor, who was active in the beginning of the 20th century, was perhaps the first to suggest systematic changes that should lead to greater efficiency within industrial organizations. The idea behind Taylor's changes was that even human systems, such as organizations, could be perceived as machines that should be optimized in order for all its parts to function efficiently (W. W. Burke, 2002). Taylor's instrumental way of perceiving human systems was contradicted by the so-called Hawthorne study that took place between 1924 and 1933. In this study, it was discovered that the presumed obvious connection between optimal workplace lighting and productivity was not found (Roethlisberger & Dickson, 1939/1967). Instead it was shown that psychological factors, such as the employees' attitudes, norms as well as the working group, leadership and possibility for autonomy were important for worker's job performance.

During the Second World War, testing and recruitment together with studies of efficiency were focused upon. This constituted the base for an extensive work developing questionnaires in order to measure work related factors between 1950 and 1960, where Rensis Likert and Kurt Lewin were two prominent figures. The ability to measure work related factors made it possible to evaluate organizational changes and models of change. Kurt Lewin suggested a three-step model for organizational change in 1951 and is still cited in books and articles about organizational change. Lewin (1951) stated that in order for a change to be carried through, three phases needed to occur: a phase of preparation (unfreezing); a phase where the change is implemented (moving); and in the third phase the change needs to be settled (refreezing). Many models have since then been developed to describe organizational changes (Blake & Mouton, 1969; Bullock & Batten, 1985; French, 1969). Depending on whether these models focus on change or development, the terms "organizational change" or "organizational development" have been used respectively. Since the end of the 1980s, organizational changes escalated to the extent that the 1990s were characterized by changes in organizational context (Quick et al., 1998). The study of organizational changes has also intensified, and there are a large amount of studies that have investigated mergers, acquisitions and downsizing, for example (e.g., R. J. Burke & D. Nelson, 1998; Cartwright &

Hudson, 2000; Isaksson, Hellgren, & Pettersson, 2000; Kivimäki, Vahtera, Pentti, & Ferrie, 2000; Kozlowski, Chao, Smith, & Hedlund, 1993; Newman & Krzystofiak, 1993; Parker, Chmiel, & Wall, 1997; Vahtera & Kivimäki, 1997).

Why do organizations change?

Changes in organizations occur, but why? In an effort to synthesize explanatory theories on why biological systems change, van de Ven and Poole (1995) conducted an interdisciplinary literature review and put together four comprehensive process theories, or in their own terms, four motors for change. According to van de Ven and Poole (1995) all theories of organizational change can be placed in one or more of these explanatory theories:

- 1) Life cycle theories resemble the development of an organization, reflecting the life cycle of a living creature or plant that goes from birth to death. Life cycle theories assume that there is an underlying logic that regulates the process of change, where every stage of development leads to the next stage in a particular sequence.
- 2) Teleological theories assume that there is a goal; one ultimate cause that guides the movement of an entity towards this goal. The goal is a social construction and changes when it is attained so that the movement begins again towards a new goal. Unlike life cycle theories, development, according to the teleological theories, does not occur in accordance with a specific order; rather, everything that leads closer to the goal is perceived as development.
- 3) Dialectical theories are characterized by confrontation and conflict between at least two parties. If one party becomes strong enough, the prevailing order is challenged and a change takes place. The changes result in a new order (synthesis) which is a combination of the previous order (thesis) and the challenger (the antithesis). When the change has been settled it constitutes in turn the prevailing order (the thesis) that once more can be challenged.
- 4) Evolutionary theories assume that organizations also fall under evolutionary laws, so that new organizations arise as a consequence of random selection and then compete for limited resources. The organizations that are best adapted for a specific environment will survive and the others will perish, which changes and develops the “population” of organizations as a whole.

These four explanatory theories for change can be classified based on two elements (van de Ven & Poole, 1995). One element refers to whether the

process focuses on the development of one single organizational entity (i.e., life cycle theories and teleological theories) or on an interaction between two or more entities (i.e., evolutionary theories and dialectical theories). The other element refers to whether the sequence of change is characterized by deterministic laws (i.e., life cycle theories and evolutionary theories) or whether they arise as a gradual process of change over time (dialectical and teleological theories). Van de Ven and Poole (1995) emphasize that most theories about organizational change are complex and contain aspects of two or more of the four theories.

The view of organizational change varies, but most studies derive from the assumption that change is an anomaly—something divergent in an otherwise stable context. This kind of perspective assumes that stability is normal and that, in essence, there exists a consensus within the system that the prevailing order is functional for all parties (Alvesson & Deetz, 2005; Burrell & Morgan, 1979). It is in fact only from this perspective that the question of why organizations do change is interesting to pose. The opposite perspective assumes instead that change is the normal state and that organizational changes derive from conflicts between different interest groups (Alvesson & Deetz, 2005; Burrell & Morgan, 1979). A partially similar view is expressed by Tsoukas and Chia (2002) when describing change as something inherent in human nature. Humans' constant will for change is the basis of why organizations are established. According to Tsoukas and Chia (2002), the legitimate question is not why organizations change, but rather, "What must organization(s) be like if change is constitutive of reality?" (p. 570; *italics omitted*).

One concept that is probably connected with the view of organizational changes as either an anomaly or as the normal state is whether the changes that are studied are dramatic, revolutionary and relatively uncommon, or if they are rather small but many and continuous. There are many terms for this division between different types of organizational change. Fundamental changes can be called radical (Greenwood & Hinings, 1996; Weick & Quinn, 1999), revolutionary (Gersick, 1991; Greiner, 1972), discontinuous (Ramanujam, 2003), transformational (Armenakis & Bedeian, 1999) or second-order (Weick & Quinn, 1999). What these various terms have in common is that they try to capture comprehensive changes that affect the profound structure of the organization. These changes are often planned and the initiative for these changes comes from upper management (Gersick, 1991). In contrast, there are many different terms also for those changes that are viewed as small and constant, such as continuous (Weick & Quinn, 1999), convergent (Greenwood & Hinings, 1996), evolutionary (Gersick, 1991; Greiner, 1972), transactional (Armenakis & Bedeian, 1999) and first-order changes (Weick & Quinn, 1999). What these terms have in common is that they try to capture ongoing changes or improvements that are constantly occurring in an organization. At times, these changes can be multiple and the source for feelings of turbulence (Gersick, 1991) without resulting in

profound structural change. Others suggest, however, that many small and continuous changes can become so extensive that, after some time, they are equivalent to a dramatic change (Orlikowski, 1996).

The assumptions about organizations (whether organizations are characterized by change or stability) and those regarding human nature (whether humans strive for change or for stability) constitute a starting point for what is studied within organizational change research. Another crucial aspect is if the changes that are studied are viewed as extensive or, rather, small and continuous. This thesis presumes that corporatization and privatization are extensive changes that constitute interruptions to organizations and that the state of normality is characterized by stability. Another assumption of the thesis is that humans generally strive for stability and that extensive change creates uncertainty and anxiety.

Driving forces for organizational change

External circumstances can be viewed as a crucial driving force that starts the process within an organization that ultimately leads to organizational change (Huber & Glick, 1993). Contrary to this, others suggest that change can take place within organizations independent of the outside world (Greenwood & Hinings, 1996). Still others argue that it is the combination of both external and internal driving forces that leads organizations to engage in change activities (Gersick, 1991; Weick & Quinn, 1999). The importance put on either internal or external driving forces may be connected with the assumption of what is driving a change, where some theories emphasize the interaction between different entities and others focus more on internal processes (van de Ven & Poole, 1995).

Internal driving forces

The highest levels of management are viewed as having extensive influence over what changes should be implemented within organizations (Gersick, 1991). They decide on what strategies, structures and culture organizations should strive for. It is the highest levels of management values, ideologies, and mental picture of reality that constitute the basis for decisions regarding the direction of the organization (Huber & Glick, 1993). The highest levels of management can also, to some extent, choose the external reality that the organization will participate in through choosing markets and products (Child, 1972). Managers of organizations tend to study each other and if a change is perceived as successful other will copy it (Sevón, 1996). To be up to date with development is important for managers of organizations and there exists a constant internal driving force to initiate change in order to follow trends and norms (Sahlin-Andersson, 1996). To what extent these changes really are implemented in the organization has, however, been

questioned and it has been suggested that the discourse of an organizational change and its practice are separate units that do not necessarily have to correspond (Brunsson, 1989).

There are some who believe that the impetus for change may come from employees who are dissatisfied with something or see a possibility of some kind, especially those who have not worked within an organization very long; they may have a critical eye and question the prevailing system (Gersick, 1991). Others argue that employees' ability to influence is often restricted (Ahrne, 1994). The opportunity for employees to initiate change is probably linked to the scale of the change. Continuous changes are constantly occurring without being initiated by the management, while major changes are almost always planned and instigated by an organization's top management (Gersick, 1991). One form of change, which has been described as unusually easy to implement compared to other changes, is to change the organization's ideas and policies so that they match how employees are already working. This could be seen as a change in which at least the contents of the change come from the employees (Brunsson & Olsen, 1993).

Another internal impetus for organizational change occurs when the system matures and grows and new needs emerge that the old structures cannot meet (Gersick, 1991). The management practices that adapt the organization to the current situation sows a seed of its own decay and leads to another period of changes in order to meet the next stage of development (Greiner, 1972). Yet another internal source of change that has been suggested is time. It has been observed that midway through a project, regardless of whether the project has been underway for an hour or several months, members of that project will become acutely aware of time (Gersick, 1989). This "time awareness" creates favorable conditions to break the inertia that would otherwise discourage change and making major change possible (Gersick, 1991). This suggests that when members of a system feel that they have time limits, they set temporal boundaries that determine when periods of equilibrium will end in favor for change.

External driving forces

Although organizations can be viewed as a form of human activity created to deal in a standardized way with a constantly changing environment (Brunsson, 1985), there are probably limits to the fluctuations with which organizations can deal before they have to change. External driving forces for organizational changes can be the result of political changes (Bozeman, 1987) such as changes in the political majority, as well as legislative changes, which can radically alter the organizations' conditions. Global political turmoil—as with the fall of communism in Eastern Europe or the formation of the EU and EMU—is considered an external factor that affects many organizations (cf. Huber & Glick, 1993). Fluctuation in the economy is another factor that affects a variety of conditions for organizations, such as

interest rates, expenses, the ability to borrow money and the demand for products. Another important external source of change comes from consumers. This applies to consumers' constant demand for new products but also consumers' values; for example with environmental awareness, working conditions or animal rights.

The key force for many of the organizational changes from the late 1980s onwards is probably the enormous technological advancements that have occurred which meant that information, capital, goods and services could travel quickly between continents. As a result, more and more companies began to compete in a global rather than a local, domestic market (Huber & Glick, 1993; L. Magnusson & Ottosson, 2003). This placed great demands on organizations to improve their efficiency, leading to the downsizing of staff, outsourcing of ancillary services, and mergers between, or buy-outs of, organizations (R. J. Burke & Cooper, 2000; Quick et al., 1998). This development also significantly affected the public sector (von Otter, 2003).

Corporatization and privatization

The requirements for cost-consciousness and efficiency in the public sector were external drives to many of the privatizations that took place worldwide in the 1990s (Ferlie, Ashburn, Fitzgerald, & Pettigrew, 1996; Öhrming & Sverke, 2001; von Otter, 2003). In Europe, countries such as Britain, Italy, Germany and Spain carried out sweeping privatizations. In Asia, economies moved towards increased liberalization particularly in China and India, partly through privatization. In South America, many countries embraced privatization. In Africa, privatization has not been particularly prevalent, excluding Nigeria and South Africa. One geopolitical area that stood out in terms of privatization was the former Soviet states in Eastern Europe where, after the fall of communism, privatization was used as a tool in the comprehensive process of converting the entire social system into market economies (Megginson & Netter, 2001). Since social situations differ so widely between developing and industrialized countries, it is recommended to distinguish between privatization made in different social systems (Megginson & Netter, 2001). This thesis derives mainly from research relating to industrialized countries. Still, the purpose of privatization has been similar in many countries and some reasons for it include the following: attracting capital to the state; increasing economic efficiency; reducing government interference in the economy; increasing competition; and exposing more businesses to market forces (Megginson & Netter, 2001). In Sweden, an intermediate form of privatization was also used involving the formation of publicly owned stock companies.

What is corporatization and privatization?

Corporatization refers to a public organization that transforms into a corporation. The company's activity is regulated under corporate law (Companies Act) and the revenue is regulated by contract (Aidemark, 2005), but the company is still owned largely by the public and is usually not operated for profit. Corporatization can be seen as a step towards privatization (Öhrming & Sverke, 2001) or even as a form of privatization (Lundqvist, 1991).

Privatization is a term that can mean several different things. One way to define privatization is that the ownership or control of public functions is transferred, in whole or in part, to a private operator (Ramamurti, 2000). Privatization could also be defined according to whether the financing of certain activities are collective or individually determined, and whether production takes place via the public or private sector (Donahue, 1989). In addition to financing and production, the regulation of a certain activity may itself be privatized (Lundqvist, 1991). It is sufficient that one of these functions (i.e., the financing, production or regulation) is transferred to private management to say that a privatization has taken place (Lundqvist, 1991). Privatization could also apply to the sale of state property, such as real estate or capital (Blomqvist, 2005).

The functions that are privatized often depend on the area concerned. Within the healthcare sector in Sweden, it is primarily production that is being transitioned into private management, while almost all financing comes from public funds. In other contexts, privatization involves a reduction or removal of government subsidies, which are replaced with user fees (Lundqvist, 1991). Fees to state-owned museums are examples of such user fees. In other cases, privatization involves a deregulation that allows a more unrestrained competitive relationship, such as in the Swedish pharmacy market. Private businesses are allowed to establish themselves as an alternative within an area that had previously only been reserved for the public sector. This can result in a reduction of the state's dominance in a particular area for the benefit of private alternatives (Blomqvist, 2005).

The distinction between public and private has been used as each other's opposites, which represents fundamentally different values (Perry & Rainey, 1988). The word "public" derives from the Latin word for "people" and represents the collective. The word "private" comes from the Latin word for "deprived", and occurs when the collective is deprived of something for the benefit of the individual (Bailey, 2000). There are many differences between public and private activities, even if the distinctions between these two concepts are ambiguous (Bozeman & Bretschneider, 1994; Donahue, 1989). For profit-driven private businesses, one primary objective is profit for the owners; among other things, this necessitates an avoidance of customers who cannot pay, to maximize the difference between revenues and costs, and the dissemination of ideas to competitors (Jacobsson, 1993). In this form of

business, the customer becomes a powerful factor since they account for the company's revenue. However, if revenues do not cover costs within the public sector, the same threat of financial bankruptcy does not exist. A public organization's existence is not dependent to the same extent on the users' perceptions, but rather on political decisions (Megginson & Netter, 2001). Although the public sector's main objective is to promote the common good (Perry & Rainey, 1988), it may be unclear what this means for any particular organization. Planning for public affairs is a politically controlled (i.e., municipality, county or state) activity. Unlike a private business, politicians have more goals than just maximizing the potential of a particular business (Blomqvist & Rothstein, 2000).

Criticism has been directed towards a strict division of public and private organizations and it has emphasized that what is public and what is private is not a simple distinction (Donahue, 1989). It has been argued that all organizations in principle are public, since all organizations to some extent are governed by decisions of the state (Bozeman, 1987). At the same time, public organizations get ideas and models from the business world (Sahlin-Andersson, 1996), as is seen with New Public Management (Ferlie et al., 1996), reinforcing the similarities between the private and public organizations. Some suggest distinguishing between public and private by looking at them as two extremes, and that most organizations find themselves in some position along the continuum between these two points (Megginson & Netter 2001).

Consequences for employees

From the standpoint that there is a difference between public and private activities, and that corporatization and privatization are major changes affecting the basic structure of organizations that are, in essence, stable assumes that these kinds of organizational changes have significant implications for employees' work climate, work-related attitudes and ill-health. These consequences are assumed to depend on the interaction between the situation (i.e., the change) and the person (i.e., the individual's experiences, interpretations and characteristics) (cf. James & Sells, 1981; D. Magnusson, 1981). Analyzing the situations that people find themselves in is therefore an important element in trying to understand individual responses to change. At the same time, mere knowledge of the situation is not sufficient since people actively interpret situations based on their own experiences, objectives, interests and conditions (Ekehammar, 1974; James & Sells, 1981; Lazarus & Folkman, 1987). An individual's experience constitutes the basis for cognitive schemas that are used to easily and rapidly interpret information from the outside world. Since all individuals carry their personal experiences with them, the same situation can be perceived differently by different individuals (James & Sells, 1981). One reason that change may elicit strain is that constructed cognitive schemas are not

adapted to the new situation, which may imply that automatic reaction patterns are no longer functional. These reaction patterns save time and energy and to some extent buffer strength to deal with constant, minor changes. However, the more extensive a change is the less effective the previous reaction patterns are and a greater effort is needed to change constructed schemas (Armenakis & Bedeian, 1999).

How change is perceived and interpreted is therefore a crucial factor for the consequences for the individual. Change is often perceived as creating uncertainty (Ashford, 1988; Bordia, Hunt, Paulsen, Tourish, & DiFonzo, 2004; Gersick, 1991; A. Nelson et al., 1995; Olson & Tetrick, 1988; Paulsen et al., 2005) because in the nature of change lies unpredictability about the future. A change implies that what has been will not remain and that something new takes place instead. Even though some may perceive change as a challenge, an unpredictable future makes it difficult for individuals to determine whether they have the resources needed to cope with new demands that come with a change (cf. Lazarus & Folkman, 1984). The uncertainty associated with organizational change has, in previous research, been shown to be associated with negative consequences for employees, such as more stress, poorer health and more negative work-related attitudes, such as lower job satisfaction and an increased willingness to resign (Ashford, 1988; Bordia et al., 2004; Olson & Tetrick, 1988; Shaw, Fields, Thacker, & Fisher, 1993). For example, the initial phase of an organizational change poses the greatest uncertainty and has been shown to be more adverse to health than the change itself, and rumors of possible layoffs have been shown to give worse health consequences than when a dismissal is realized (Dekker & Schaufeli, 1995; Ferrie, Shipley, Marmot, Stansfeld, & Smith, 1995; Paulsen et al., 2005).

The extent of the uncertainty that a change generates is probably dependent on the form of organizational change to which it refers. Downsizing may be associated with the uncertainty of losing work (Parker et al., 1997) as well as concerns about an increased workload (Kivimäki et al., 2000). Organizational changes in the form of downsizing have been shown to be associated with increased mental and physical complaints and negative work attitudes (Isaksson et al., 2000, Kozlowski et al., 1993; Vahtera & Kivimäki, 1997). Even organizational expansion may be associated with job strain and an increased risk of cardiovascular disease (Westerlund, Theorell, & Alfredsson, 2004). In cases where privatization has led to extensive cutbacks of personnel, change has also been shown to be associated with poorer physical and mental health (Ferrie et al., 2001; Ferrie, Shipley, Marmot, Stansfeld, & Smith, 1998). Economically, it has been shown that privatization, in most cases, leads to increased efficiency and greater profitability (Megginson & Netter, 2001) which is often related to various forms of rationalization. It has also been assumed that higher efficiency leads to a greater workload (Cunha, 2000), as staff also have testified to in interviews made after corporatization (Aidemark, 2004). The higher

workload could be a contributing factor to the deterioration of health that has been shown in privatization studies (Cunha, 2000; A. Nelson et al., 1995).

Mergers or acquisitions can create anxiety as individual workers feel that a part of their identity is threatened during ownership and organizational culture change (R. J. Burke & D. Nelson, 1998). Mergers and acquisitions have been shown to be associated with increased stress (Cartwright & Hudson, 2000), poor working environments (e.g., less autonomy and feedback), and more negative work attitudes (e.g., less commitment and less job satisfaction among employees) (Newman & Krzystofiak, 1993). As with mergers and acquisitions, privatization implies a change of ownership (R. J. Burke & Cooper, 2000). Work culture has also been shown to change within an organization that goes from public to private; nevertheless, it has been shown to paradoxically increase both job satisfaction and mental and physical ill-health among employees (Cunha & Cooper, 2002).

Organizational changes aimed at enriching the work experience—for instance, through the staff receiving more autonomy, more opportunities to vary their tasks and explicit feedback on performance (cf. Hackman & Oldham, 1976)—have shown to be positive for employees (Griffin, 1991; Orpen, 1979; Umstot, Bell, & Mitchell, 1976). The increased efficiency that a privatization, and perhaps a corporatization, implies could make the organization use both financial and human resources in a better way, which is probably perceived as positive by the employees (Cunha, 2000). Corporatization has been perceived as positive by some employees who have described the change as a “boost” to develop the organization (Aidemark, 2004). Leadership has also been deemed as more positive in corporatized hospitals compared with public hospitals (Falkenberg et al., 2004; Wallenberg, 2001) and commitment to the organization has even been shown to be stronger in corporatized hospitals compared with hospitals that were run as public administration units (Sverke et al., 1999).

Social status

Social status is important in many contexts because of its significance for both mental and physical health (Adler, Epel, Castellazzo, & Ickovics, 2000; Adler & Rehkopf, 2008; Marmot, 2004; Steptoe et al., 2003; Wilkinson, 2005). Social status is also a crucial factor for work life since organizations are hierarchical (Henry, 2005); this implies an uneven distribution of resources. Those who have higher status have greater access to resources and thus more control than a person with lower status (Lachman & Weaver, 1998; Lynch & Kaplan, 1997; McLeod & Kessler, 1990; Marmot, 2004; Ridgeway, 1991; Wilkinson, 2005). Resources and control are important factors for coping with situations that place demands on employees and require adaptation (Karasek & Theorell, 1990; Lazarus & Folkman, 1984). Two status factors that have been suggested to be important in organizational change are hierarchic level (Swanson & Power, 2001) and gender (Tienari, 1999). Before these factors are discussed in more detail, social status and its consequences are described on a general level.

Social status and its consequences

Social status is one of the strongest predictors of mental and physical health and mortality (Adler et al., 1994; Adler & Rehkopf, 2008; Lynch & Kaplan 1997; Marmot, 2004). Social status is defined either by using objective markers such as income, education, occupation, position, ethnicity and gender, or using the individual's subjective experience of their status. The association with health and mortality exists no matter how social status is measured, but the relation may be slightly different depending on the measure used for social status and the outcomes studied (Geyer, Giancarlo Corsetti, Peter, & Vågerö, 2006; Lynch & Kaplan, 1997).

Some explanatory models regarding the association between social status and health and mortality focus on objective explanations, while others focus on more subjective experiences. Theories with a more objective perspective point out that access to material resources—for example, access to healthcare, the quality of education, housing and working environment—separates people with different status (Lynch, Smith, Kaplan, & House, 2000). That individuals with low social status tend to have poor access to such resources while individuals with high status have good access is

considered, from this standpoint, to be the main explanation for differences in health. Theories with a subjective perspective attribute significant importance to the perception of having less access to resources with its subsequent impact on health (Marmot, 2004; Wilkinson, 2005). Having less access to resources is related to experiences of injustice (De Vogli, Ferrie, Chandola, Kivimäki, & Marmot, 2007) as well as discrimination and devaluation (Wilkinson, 2005). Through these experiences, employees could react with frustration that ultimately could lead to strain and ill-health. (Adler et al., 2000; Cohen, Doyle, & Baum, 2006; Marmot, 2004; Marmot & Smith, 1991; Steptoe et al., 2003; Wilkinson, 2005). According to this view, it is the relative difference that is crucial for health, not absolute levels of wealth. This reasoning is supported by the finding that countries that have a smaller proliferation of social status (defined as income) generally have a higher life expectancy than countries that are nevertheless richer, but have social differences that are more extensive (Wilkinson, 2005). Thus, it is not how rich a country is (as measured on the basis of gross domestic product [GDP], provided that the per capita GDP exceeds a certain basic level) that has a bearing on life expectancy, but how equal the distribution of resources is in the country (Wilkinson, 1992).

Despite some disagreement about the mechanisms underlying the link between social status and health, there are still some consistent results. One such result is that the health differences that emerge do not only exist between those with very high social status compared to those with very low status; the relationship is linear and positive, so that those with slightly higher social status have better health than those with slightly lower status (Adler et al., 1994; Lynch et al., 2000; Marmot, 2004; Wilkinson & Pickett, 2006). Another consistent finding is that social status has to do with access to resources in any form (Adler et al., 1994, Geyer et al., 2006) and the ability to feel a sense of control. It could be exercising control over material and economic factors (Lynch et al., 2000), over life situations (Marmot, 2004), or over a work situation (Geyer et al., 2006).

Additionally, an issue that has been raised is that people with different social status are exposed to different amounts of stressful circumstances, such as loss of income due to unemployment or because of unexpected expenses, divorce or the loss of someone close (Adler et al., 1994; Marmot & Smith, 1991; McLeod & Kessler, 1990). People with lower social status may thus be at a greater risk of being subjected to more stressful circumstances and also have fewer resources to cope with these situations (Davidson, Kitzinger, & Hunt, 2006; McLeod & Kessler, 1990).

Another issue that has been discussed is whether the relationship between social status and health is the reverse; that is, that health is relevant to what status the individual has. This cannot be ruled out and needs to be further investigated (Adler & Rehkopf, 2008; Garbarski, 2010). Still, many studies suggest that social status is more important to health than health is to social status (Adler et al., 2000). The relationship between social status and health

could also be due to some third factor. Investigations into various factors that are related to both social status and health have been studied and include such as smoking, alcohol consumption, obesity and physical activity (Cavelaars, Kunst, & Mackenbach, 1997; Marmot & Smith, 1991). Even after controlling for these factors, the relationship between social status and health remains (Adler et al., 1994; Smith, Shipley, & Rose, 1990). Cognitive capacity is more difficult to exclude as an underlying factor for social status and health (cf. Deary, Whiteman, Starr, Whalley, & Fox, 2004; Gottfredson & Deary, 2004). However, there is probably not a simple relationship but a complex combination of genetics and environmental factors (Adler et. al., 1994). Whatever the mechanisms behind how social status is created, which still seems unclear, a linear positive relationship between social status and health seems apparent (Adler & Rehkopf, 2008).

Hierarchic level as a marker for social status in the context of organizational change

In industrial societies, occupations constitute an important marker of social status (Sing-Manoux, Adler, & Marmot, 2003). Occupation and position are often the measure for the financial resources and prestige that a person can achieve in a society. The status associated with an occupation and position is also closely related to the amount of power and authority within an organization, along with access to resources and opportunity to exercise control (Geyer et al., 2006; Marmot & Smith, 2001; Martin et al., 2006). Within an organization these resources are, for example, composed of the ability to influence and participate in decisions, access information and to social networks (Ashford, 1988; Heller et al., 1998). The higher the occupational level and status an employee has, the greater the access to resources. The employee also tends to be better equipped to control the course of events; for example, during organizational change.

The balance between perceived demands and resources is emphasized in several theories about the experience and handling of stress at work (Demerouti et al., 2001; Karasek & Theorell, 1990). Stress is likely to occur if the demands are perceived to exceed the resources available at hand (Lazarus & Folkman, 1984), and long-term stress has many negative consequences for both mental and physical health (Frankenhaeuser, 1991). Even if the requirements are substantial, these can, however, be compensated for if the access to resources is extensive enough (Karasek & Theorell, 1990).

The amount of requirements and availability of resources are especially important in a stressful situation that entails new demands and require adjustments, like during organizational change (Moyle & Parkes, 1999; Paulsen et al., 2005). The implications of the new requirements and the

uncertainty arising from the change are probably due, in large part, to the availability of resources, such as information and ability to influence and control the change (Bordia et al., 2004). The more resources an employee has, the greater the possibilities are that the situation will seem easier to cope with. Therefore, it is likely that employees at high levels find it easier to handle the requirements that organizational change implies than employees at lower levels (Olson & Tetrick, 1988; Swanson & Power, 2001). Employees at high levels, however, often have a greater workload than staff at lower levels (Frankenhaeuser et al., 1989) which could make these employees in high positions vulnerable to an even greater burden with regard to a change. Employees at a high hierarchic level are also often more responsible for implementing organizational changes, which can create anxiety and stress (Martin et al., 2006; Swanson & Power, 2001; Väänänen, Pähkinä, Kalimo, & Buunk, 2004). Results from previous studies have shown that managers felt change was more stressful, a bigger disturbance and more difficult to handle compared to employees at lower levels, due to a higher workload and greater responsibility for the change (Martin et al., 2006; Swanson & Power, 2001). Meanwhile, employees at higher levels proved to have more control over the change, greater commitment to the organization (Martin et al., 2006; Miles, Patrick, & King, 1996) and more positive attitudes towards change (Hunsaker & Coombs, 1988) than employees at lower levels.

Employees at lower hierarchic levels have been shown to experience greater inequity and have fewer opportunities to control organizational changes than employees at higher levels; this has resulted in more negative work attitudes, such as less commitment and greater turnover intention (Armstrong-Stassen, 1998; Henry, 2005; Hunsaker & Coombs, 1988; Martin et al., 2006). The extent to which an employee is at all affected by a change is another factor that must be taken into account. Some changes can be perceived as widespread by employees at a high hierarchic level, who will drive the change, while the work does not change much for the employees at a lower hierarchic level (Swanson & Power, 2001; Tienari, 1999). For those whose work situation is hardly affected by the change process, organizational change probably generates neither positive nor negative effects (cf. Lazarus & Folkman, 1984).

There is as yet little research on how employees at different hierarchic levels are affected by organizational changes in the form of corporatization or privatization. For the corporatization of two hospitals in southern Sweden, interviews showed that there were no major differences in opinions on corporatization for employees in occupations at three different hierarchic levels (physicians, registered nurses, assistant nurses). At one of the hospitals, all of these groups expressed positive feelings toward the corporatization. The opinion among these groups was that decisions could be made more easily and that there existed a constructive dialogue between staff and management (Aidemark, 2004). Both registered nurses and

assistant nurses reported that they received more information than before. At the other corporatized hospital, staff at all three levels expressed negative views about the change: while they felt that decisions could be made faster, the hospital was considered to have become more run from the top and the union was perceived as being marginalized (Aidemark, 2004). With a privatization of a regional water company in the UK, subsequent structural changes, in contrast, showed differences between the hierarchic levels. Employees at a low hierarchic level particularly experienced substantial amounts of uncertainty and little control related to the privatization and it was that group who reported the most negative consequences regarding job satisfaction and mental and physical health (A. Nelson et al., 1995).

Gender as a marker of social status in an organizational change context

Gender is one of the most fundamental principles used to organize social relations (Beall, Eagly, & Sternberg, 2004) and is systematically related to status (Ridgeway & Bourg, 2004). Men in most societies have more power and higher status than women (Pratto & Walker, 2004) which, in the same way as the status in terms of occupational level, is likely to be relevant in an organizational change.

As already noted by Marx and Weber, people with high social status and power are the ones who create the norms and values that arise in a society (Rothman, 2002). The man is the norm in most contexts, not least in the working life (Ridgeway & Correll, 2004). Since the industrial revolution, the image of the ideal worker has been a man whose work is not influenced by family (Gamble, Leis, & Rapoport, 2006). At higher levels, this is particularly significant where the ideal manager shows complete dedication and commitment by working long hours and devoting all energy to work. This standard of the ideal worker still seems to persist despite the fact that women in many countries are working to almost the same extent as men (Eurostat, 2008). To depart from the norm of the ideal worker, by being a woman for example, may imply a lower social status (Ridgeway & Correll, 2004).

One way to understand this difference in social status is by the stereotype that men are considered to be valued as more superior and more competent than women. This gives men preference to leading positions that require responsibility and the ability to act (Ridgeway, 2001). Competence is closely related to power in that the ones who are perceived as more competent are listened to more, implement their proposals with greater ease and have more influence (Ridgeway, 1991). This is particularly evident in a group composed of women and men that needs to solve a task together, which is common in the working context (Pugh & Wahrman, 1983). A higher

competency also legitimizes gaining greater rewards and access to more resources (Ridgeway & Correll, 2004). Stereotypes of women as more emotional and caring, in turn, act as precedents for placing them in positions where these qualities are considered essential (Ridgeway & Bourg, 2004). These conditions are reflected in a labor market that is both horizontally and vertically segregated, so that more women are working in the healthcare sector or the education system and generally have lower positions than men (Eurostat, 2008).

Even when women and men are working at the same level, there may be status differences between the genders. For example, it was shown in a study of female- and male-dominated departments that worked with customer service in a Swedish telecom company that women experienced significantly less autonomy and described their work situation as more regulated than the men (Torkelson et al., 2007). Also, a study of women and men who worked as managers and specialists in a Swedish insurance company revealed that the situation was less favorable for women than men (Lundberg & Frankenhaeuser, 1999). Both groups reported that their work provided a platform for development, variety and autonomy. Nevertheless, women reported lower levels of these factors compared with men. The women also experienced more stress due to lack of communication and lack of support from their closest supervisor. This picture is still not entirely clear. In a study of academic staff in which women reported more mental and physical health problems—even after control for occupation—other gender differences, such as the amount of interpersonal conflicts, disappeared after having controlled for occupation (Liu, Spector, & Shi, 2008). Another study of women and men working as managers in the sales department of a Swedish telecom company did not reveal any differences in perceived control. On the other hand, there were gender differences in the factors which contributed to health problems. For women, the major sources of health problems were workload and difficulties combining the demands of work and family, while lack of control was the factor that contributed most to men's ill-health (Torkelson & Muhonen, 2003).

The demands for women and men working at the same hierarchic level should be comparable, but there are results suggesting that “all things being equal”, requirements are higher for women than for men (Pugh & Wahrman, 1983). Women often perceive that they have to perform better at work than men to be judged as equally good (Frankenhaeuser et al., 1989; Karambayya, 1998; Muhonen, 1999). In addition, women continue to have the overall responsibility for unpaid work, although the degree of paid work is almost equally high as for men, making women's total workload generally larger than men's (Lundberg, 1996; Lundberg & Frankenhaeuser, 1999). If women have more demands put on them than men, these demands would have to be accompanied by a larger amount of resources in order to not adversely affect women's health.

There are different opinions of what an organizational change may imply for women compared with men. The loosening of the power structure that an organizational change may imply has been mentioned as a chance for women to advance in organizations (Collins, 2005). It has also been reasoned that women constantly experiencing uncertainty and insecurity in work life would thus be more equipped to cope with these feelings when they occur in an organizational change (Karambayya, 1998). Other research suggests that many changes may be more detrimental for women than for men (Collins, 2005). Women often have low or temporary positions (Corral & Isusi, 2004) and these are the jobs that are hit hard when organizations implement cutbacks. Women also often hold positions that do not deal directly with the core business and are often outsourced (Karambayya, 1998). Organizational changes often carry a heavy workload, greater demands for flexibility and an increased presence (Karambayya, 1998), and as long as women have the main responsibility for unpaid work, all of these consequences of organizational change may be more difficult for women to handle than for men.

That there may be gender differences in social status, access to resources and the amount of requirements has been shown in studies of physicians. Numerous studies and doctoral theses point to the hegemonic masculinity that characterizes the ideal image of the physician (D. Bergman et al., 2009; Eriksson, 2003; Fridner, 2004; Risberg, 2004). This has shown to have an impact on a variety of factors: it has been found that women working as physicians experience it to be more difficult to exert influence over their own and others' work, tend to be valued less than men physicians, feel discriminated against (for example, with regard to career development), experience difficulties reconciling work with family, have less social capital than male counterparts, and may become excluded from the "inner circle" of power and influence (D. Bergman et al., 2009; Miller & Clark, 2008; G. E. Robinson, 2003). Women and men who work as physicians are also treated in different ways by colleagues and nurses. For example, female physicians are expected to make fewer demands on service and support from nurses, and are expected to be available in a different manner than their male colleagues to other physicians, nurses and patients (Eriksson, 2003; West, 1993).

So far, studies of women and men working in the same hierarchic level within the context of organizational change are rare—regardless if the changes take place in healthcare or in other businesses. Particularly rare are studies of corporatization and privatization from a gender perspective.

Method

This methodological section briefly describes the external factors that contributed to two of the three acute hospitals examined in this thesis that underwent corporatization and privatization. A description of what happened at the three hospitals investigated during the years of the study follows. Finally, there is information on the sample and the attrition for the three studies and a description of the variables used in the thesis.

Background to the changes in acute care hospitals

Since the 1980s in Sweden, there has been political motivation to increase competition in the public sector. This was based on dissatisfaction with the extent of the state's power over citizens. Privatization, and to some extent corporatization, were seen as ways to break the state's public monopoly and increase citizens' influence and autonomy (Blomqvist & Rothstein, 2000). More producers competing for the clients was thought to lead to cost efficiency and increased quality. An increased market-orientation of welfare services was considered the solution to increasing citizens' influence and improving quality while making the public sector more cost efficient.

These economical and ideological concepts had an impact on the healthcare sector. The economic aspect was of particular importance for growing market-governance in the sector. Healthcare costs had risen steadily since the 1960s and there was reason to believe that growth would continue as the proportion of elderly people in the population rose and the development of medical science resulted in constantly increasing demands for treatments, medicines and equipment from both patients and healthcare professionals (Blomqvist & Rothstein, 2000). A wave of decentralization in the public administration of services was carried out, starting in the middle of the 1980s and a series of changes that would strengthen citizens' freedom of choice and create a dynamic market economy in healthcare were conducted in Sweden during the 1990s (Blomqvist, 2004). Different counties imposed local versions of market-governance, of which the common features were a separation between financing and production, decentralization of budget and personnel responsibility, as well as procurement that allowed for private (including for-profit) operators to compete for public contracts (Blomqvist, 2005). One of the reforms—the so-called Stockholm model—

occurred in the Stockholm County Council in 1992. The reform meant, among other things, that patients would have greater power to choose healthcare providers. The County Council became the purchaser of healthcare, on behalf of the patients, while the healthcare providers (i.e., hospitals and other health services) became producers (Öhrming, 1997). Among the most dramatic manifestations of the growing element of market management in the Stockholm County Council was the 1994 corporatization and the 1999 privatization of St. Göran's hospital (Öhrming & Sverke, 2001). After St. Göran, a number of acute care hospitals in the Stockholm County Council were corporatized, including Danderyd's Hospital in 2000. Hospitals that were corporatized were transformed into publicly owned stock companies, with the county as the owner of all shares. Privatization meant that the council sold the shares in the company to a private owner.

The hospitals in the thesis

Below is a brief description of what occurred at the three acute care hospitals that are included in the thesis studies. All of the hospitals are located in the Stockholm region. The description is mainly focused on the period in which the studies were conducted, from 1998 to 2002. The case of St. Göran's also describes a corporatization, which occurred earlier, as a background to the privatization.

The privatized St. Göran's Hospital

The first of January 1994, St. Göran's became the first acute care hospital in Sweden to corporatize, transforming into a company that was owned by the Stockholm County Council and that would operate as a non-profit organization. In connection with the corporatization, the name was changed to St. Göran's Hospital AB. An executive director was appointed in the autumn 1993 and a board was appointed at the end of 1994. With the corporatization, a clear division of responsibilities and authority was made between the council and St. Göran's which allowed direct governance of the hospital from the management and board. The executive director emphasized replacing the old management thinking with a new market-oriented and cost-conscious mindset. With the corporatization, the responsibility for hiring personnel moved from the county council to the hospital (Öhrming & Sverke, 2001).

The formal decision to sell St. Göran's Hospital AB to a private operator was taken in November 1999 and the sale went through on 31 December 1999. The investment company "Bure Hälsa och Sjukvård AB" (now Capio AB) took over the majority of shares and thus the entire business and staff (St. Göran's Hospital AB, 1998, 1999). A new board was appointed in January 1999 and the board was changed again in early 2000. A new

executive director took office in April 2000. Since the corporatization, St. Göran's has sold off services and co-operated with other caregivers. The establishment of a board and chief executive officer (CEO), attaining independence from the county council, and developing the practice of setting separate goals were all habits practiced after corporatization (Öhrming & Sverke, 2001, 2003). The real change that the privatization brought on was that instead of the county council, the hospital had a private owner. Another important change that privatization brought on was that the hospital became a profit-making activity with real return requirements to the owners and goals for increased growth. Profitability and expansion thus became high priorities on St Göran's agenda (Öhrming, 2008).

Corporatized Danderyd's Hospital

Danderyd's Hospital was transformed from a public administration-run hospital to a company owned by Stockholm County Council in 2000. At the corporatization, the hospital changed its name to Danderyd's Hospital AB. The corporatization meant that a board and an executive director were appointed. In connection with the corporatization, personnel employment duties went from the county council to the company. During the corporatization, only a few employees chose not to follow to the company (Danderyd's Hospital AB, 2000). Corporatization implied a clearer division of responsibilities between the county and the hospital as well as within the hospital. Governance of the hospital also changed: before the corporatization business plans, budgets and follow-up were discussed essentially only once a year and deviations from the budget were not considered serious. With corporatization, this system changed radically and operational plans, budgets and follow-ups were key elements of the hospital's management systems. Furthermore, deviations from these were followed-up closely (Öhrming, 2008).

In the context of corporatization some operations moved to or from the hospital. In addition, management discussed various forms of outsourcing, partnerships and the formation of limited companies together with other operators to provide different types of care. As a result, the hospital opened a private maternity ward together with "Praktikertjänst" in 2000 (Öhrming, 2008).

The public administration-run Södertälje Hospital

Södertälje Hospital underwent no change of ownership during the period of study for this thesis but was an administration-run hospital under the aegis of the Stockholm County Council. The county council administration was responsible for the hospital's operation and activities. Nevertheless, some restructuring took place during the time of the study. In 2000, a new surgical ward was opened and in 2001 the maternity care wing was enlarged. In the

same year, the catchment area was also extended. In addition, a flexible working time model was introduced, which meant that work schedules could essentially be adapted for staff preferences. Similarly, the digital health system, Cambio, was introduced between 2000 and 2002. This system facilitates the charting of patients and administration (Södertälje Hospital, 1998, 1999, 2000, 2001).

A new vision was produced by the management team at Södertälje Hospital in 2000 and in that year began the process of passing it on to all employees at the hospital. The vision was that the work at the hospital would be characterized by professionalism, commitment, accessibility and cooperation (Södertälje Hospital, 2000).

Samples

The three studies included in this thesis are involved in a larger research project that included St. Göran's and Södertälje hospitals as focus for research since 1994. Survey studies, with questionnaires distributed to all staff at both hospitals were conducted in 1994, 1996, 1998 and 2001/2002. During the last data collection period (2001/2002), Danderyd's Hospital was also included. Figure 2 provides an overview of data collections in relation to the type of ownership changes that occurred during the project. The data used for the studies in this thesis come from the last two data waves. Henceforth, the last two data collection periods will be referred to as Time 1 and Time 2 in the thesis.

The data collection was carried through in a standardized way. The questionnaires were sent home to all of the staff in the hospitals along with a letter explaining the purpose of the investigation. The letter also assured that the responses would be confidential and it was clarified that it was completely voluntary to answer the questionnaire. Another letter, in which hospital management at each respective hospital expressed their support of the investigation, was sent out and a postage-paid return envelope was included in the mail to facilitate answering the questionnaire. Those who had not responded to the questionnaire after a certain period of time received a maximum of three reminders. The response rates for all hospitals varied between the different data collection waves. The lowest response rate, when all hospital employees were included, was 58% and the highest 77%, but the response rate typically varied between 65% and 70%. The response rates for St. Göran's Hospital were 58% in 1998 and 60% in 2001/2002. For Södertälje Hospital, the response rates, when all employees were included, were 65% both in 1998 and 2001/2002, and for Danderyd's Hospital, the response rate was 73% in 2001/2002.

Figure 2. Data collections and changes in ownership at the three hospitals studied. The marked field shows the data collections that are part of the thesis.

Sample for Study I

The data collection for Study I took place 2001/2002 in all three hospitals: administration-run Södertälje Hospital; corporatized Danderyd's Hospital; and privatized St. Göran's Hospital. Sampling frames and response rates for physicians at the three hospitals are presented in Table 1. The study was comprised of physicians who had completed data for all variables included. The 78 physicians from the administration-run Södertälje Hospital were an average of 45 years of age ($SD = 11$ years), 44% were women and they had worked an average of six years at that hospital ($SD = 8$). From the corporatized Danderyd's Hospital, there were 217 physicians who had complete data for all variables. Their average age was 44 years ($SD = 10$), 48% were women and the average tenure in the organization was eight years ($SD = 9$). From the privatized St. Göran's Hospital there were 114 physicians included with the average age of 45 years ($SD = 10$), 33% were women and their average length of employment at the hospital was 6 years ($SD = 7$). There were no differences between the physicians at the three hospitals in terms of age, length of employment or gender. In contrast, those who had complete data were slightly older and had worked a longer time in the hospitals than those who were not included in the study due to internal attrition. There were, however, no gender differences between the effective sample and the internal attrition.

Table 1. Sample and response rates for physicians in Study I (data from Time 2).

	Administration-run	Corporatized	Privatized
Total number of physicians	149	351	207
Number of responses from physicians	91	239	124
Response rate	61%	68%	60%
Internal attrition	13	22	10
Final sample	78	217	114

Sample for Study II

The data collection for Study II took place first in 1998 and subsequently in 2001/2002 at St. Göran's hospital, which was privatized in 1999, and at Södertälje Hospital, which was public administration-run when the study was conducted. Sampling frames and response rates for healthcare employees at the two hospitals are presented in Table 2. The study included those who responded to the questionnaire at both data collection sessions and who also had completed data for all variables. This resulted in an effective

sample for the privatized hospital of 179 employees (39 physicians, 84 registered nurses and 56 assistant nurses). They had a mean age of 43 years ($SD = 10$), had worked an average of 10 years ($SD = 8$) at the hospital and 76% were women. At the public administration-run hospital the effective sample totaled 219 employees (20 physicians, 98 registered nurses and 101 assistant nurses). Their average age was 46 years ($SD = 10$), the average tenure was 15 years ($SD = 9$) and 84% were women.

Table 2. Sample and response rates for healthcare employees in Study II.

	Administration-run		Privatized	
	Time 1	Time 2	Time 1	Time 2
Total number of healthcare employees	842	957	954	1090
Number of responses	583	700	544	620
Response rate	69%	73%	57%	57%
Longitudinal sampling frame	-	325	-	269
Longitudinal sample	-	274	-	214
Response rate long sample	-	84 %	-	80%
Internal attrition	-	55	-	35
Final sample	-	219	-	179

Because of the long amount of time between the two data collection periods, attrition was abundant; therefore, a non-response analysis was conducted. The analysis showed that those who had left the hospital at the time of the second data collection period were younger, had worked for a shorter time at the hospital, were less satisfied with their job, had stronger intentions to leave the hospital and were more exhausted (and at the privatized hospital, also less committed to the organization) than those in the longitudinal sample. The pattern was the same at both hospitals. However, there were almost no differences at any of the hospitals among those who constituted the effective longitudinal sample and those who remained with the hospitals but who chose not to respond during Time 2. This suggests that the responses were representative for the longitudinal sample at the two hospitals. That the patterns of attrition were similar in the two hospitals reduces the risk that the comparison of the developments in the hospitals were affected by the so-called "healthy worker" effect" (Östlin, 1989).

Sample for Study III

The data used in Study III was collected in 2001 at Danderyd's Hospital, which had been corporatized the year before. This study was based on data from the women and men who worked as physicians at the hospital. Sample frames and response rates for the physicians at the hospital are shown in Table 3. After controlling for multivariate outliers, 200 physicians (95

women, 105 men) were included who had completed the data for the variables in the study. The women had on average worked for 6 years ($SD = 6$) at the hospital, 15% had a supervisory position and 61% had a permanent employment. The men had worked an average of 11 years ($SD = 10$) at the hospital, 29% had a supervisory position and 85% had permanent employment. Women and men differed significantly in terms of tenure at the hospital, supervisory positions and employment contract and these factors were controlled for in further analyses.

Table 3. Sample and response rates for physicians in Study III (data from Time 2).

	Women	Men
Total number of physicians	178	173
Number of responses from physicians	116	123
Response rate	65%	71%
Multivariate outliers	6	4
Internal attrition	15	14
Final sample	95	105

Measures

The questionnaires used to collect the data contained many variables in different areas, such as background, work climate, work attitudes, health and questions related to the union. The variables included in this thesis are a selection of the variables included in the questionnaire. Variables included in the thesis are, as far as possible, based on established scales. Reliabilities (Cronbach's alpha) were, in general, above .70 and therefore considered acceptable (Nunnally, 1978). Table 4 presents the variables used, the number of items for each variable, source, scale range, example items and reliabilities.

To capture employees' perceptions of their work, the project used James and Sells (1981) theory of psychological climate (also called work climate in the thesis). This theory assumes that employees' perceptions of their work can be divided into five different domains that characterize the employees' perceptions of their job, their role, the leadership, their workgroup and the organization. Each of these dimensions consists of several sub-scales. The names of the dimensions vary somewhat in the thesis. For instance, employees' perception of their role is called role characteristics or role stress; the dimension of organization is called organizational characteristics or organizational climate. Even for subscales, different names may be used. For example, one leadership scale, which is intended to capture how much a manager is concerned with the relations to the employees, is called

employee-oriented leadership in Study I and relation-oriented leadership in Study III and the variable autonomy in Study I has the prefix job before it in Study III. Also the variables justice and trust in Study I are named organizational justice and organizational trust in Study III.

When it comes to work attitudes (sometimes called work-related attitudes or simply attitudes in the thesis), the selection of variables for the thesis was based on what has typically been measured in other studies of organizational change in order to facilitate the comparison with other study results. The selected variables include job satisfaction, organizational commitment and turnover intention (the last variable is reversed and called intention to stay in Study III). Employee health, more often called ill-health or strain in the thesis, was measured both with the employees' self-reported mental ill-health (also called psychological or mental health complaints) and self-reported physical ill-health (also called physical health complaints), as well as emotional exhaustion which has been suggested as an important variable for health care employees (Schaufeli, Leiter, & Maslach, 2009).

Since the questionnaire had the ambition to include measures pertaining to many different areas, the space was very limited, which meant that some scales (such as the leadership scales) were reduced. The reduction of items was, as far as possible, based on tested, short-form versions of the scales.

Table 4. Overview of variables used in the present thesis.

Variable	No of items	Source	Scale range	Example item	Reliability (alpha)		
					Study I	Study II	Study III
Background							
Gender	1		1=women 0=men		(-)	(-)	NA
Age	1		Years		(-)	(-)	-
Organizational tenure	1		Years		(-)	(-)	NA
Employment contract	1		1 = perm 0 = temp		-	-	NA
Supervisory position	1		1 = yes 0 = no		-	-	NA
Psychological work climate							
<i>Job characteristics</i>							
(Job) Autonomy	4	Sverke & Sjöberg (1994)	1-5	I can make my own decisions on how to organize my work	.77-.77 ^b	-	.79 W .82 M
Job challenge	3	Sverke et al. (1999)	1-5	I'm learning new things all the time in my job	.60-.67 ^b	-	.49 W .55 M
Knowledge of results	3	Hackman & Oldham (1975)	1-5	I have a pretty good idea of whether or not I am performing my job sufficiently well	.77-.82 ^b	-	.81 W .83 M

(cont'd)

Table 4 (cont'd)

<i>Role characteristics/Role stress</i>							
Role overload	3	Beehr, Walsh, & Taber (1976)	1-5	It fairly often happens that I have to work under a heavy time pressure	.75-.77 ^b	-	.81 W .74 M
Role conflict	5	Rizzo, House, & Lirtzman (1970)	1-5	I do things that are apt to be accepted by one person and not accepted by others	.72-.74 ^b	-	.59 W .78 M
Role ambiguity	4	Rizzo et al. (1970)	1-5	There exist no clear, planned goals and objectives for my job	.75-.77 ^b	-	.77 W .77 M
<i>Workgroup characteristics</i>							
Workgroup cohesiveness	2	Nystedt (1992)	1-5	In my workgroup we help and support each other in the job	-	-	.74 W .75 M
Workgroup cooperation	2	Taylor & Bowers (1972)	1-5	In my workgroup we plan and coordinate our efforts together	-	-	.53 W .73 M
<i>Leadership characteristics</i>							
Production-oriented	3	Ekvall & Arvonen (1994)	1-4	My boss plans carefully	.83-.86 ^b	-	.82 W .86 M
Employee- (relation-) oriented	3	Ekvall & Arvonen (1994)	1-4	My boss shows regard for the subordinates as individuals	.85-.88 ^b	-	.76 W .87 M
Change-oriented	3	Ekvall & Arvonen (1994)	1-4	My boss offers ideas about new and different ways of doing things	.87-.88 ^b	-	.84 W .89 M

(cont'd)

Table 4 (cont'd)

Organizational characteristics/climate

(Org) Justice	3	Hellgren & Sverke (2001); Sverke et al. (2004)	1-5	I feel my employer treats me fair	.84-.89 ^b	-	.88 F .89 M
(Org) Trust	5	S. L. Robinson (1996)	1-5	I am sure I can fully trust my employer	.61-.94 ^b	-	.90 F .96 M
Attitude towards privatization	6	Developed for the project	1-5	I am generally positively disposed towards privately owned hospitals	.63-.88 ^b	-	-
Participation in decision-making	3	Hellgren & Sverke (2001); Sverke et al. (2008)	1-5	Employees are encouraged to participate when important decisions are made in the organizational unit	.77-.80 ^b	-	.78 F .83 M
Job insecurity	10	Ashford, Lee, & Bobko (1989)	1-5	I may be laid off permanently	.76-.80 ^b	-	-
Employability	4	Developed for the project	1-5	I could easily get another job	.70-.75 ^b	-	-
Work attitudes							
Job satisfaction	3	Hellgren, Sverke, & Isaksson (1999)	1-5	I enjoy being at my job	-	.87 T1 .89 T2	.82 F .89 M
Organizational commitment	4	Sjöberg & Sverke (2000)	1-5	I really feel as if the this hospital's problems are my own	-	.73 T1 .76 T2	.67 F 70 M
Turnover intention ^a	3	Sjöberg & Sverke (2000)	1-5	I feel that I could leave this job	-	.84 T1 .86 T2	.83 F .92 M

(cont'd)

Table 4 (cont'd)

III-health

Mental health complaints (GHQ-12)	12	Goldberg (1972, 1978)	0-3	Have you the last couple of weeks felt constantly under strain	-	.82 T1 .84 T2	.83 F .81 M
Physical health complaints	10	Isaksson & Johansson (1997); Sverke et al. (2004)	1-5	Have you in the past 12 months suffered from muscular tension?	-	.79 T1 .80 T2	.65 F .80 M
Emotional exhaustion	9	Maslach, Jackson, & Leiter (1996)	1-5	I feel emotionally drained from my work	-	.85 T1 .86 T2	-

^a Reversed to measure intention to stay in Study III^b Range of alpha-values over the three hospitals

-: Not included in the study

(-): Only included in the non-response analysis

NA: not applicable

T1: Time 1

T2: Time 2

W: Women

M: Men

Summary of studies

Study I: Physicians' work climate at three hospitals under different types of ownership

Background

Although privatization has been implemented worldwide, the effects of privatization on personnel have not been studied to any great extent (Megginson & Netter, 2001). Sweden has also corporatized many operations (Berg, 1999) but little is known about how such a change could affect employees.

Aim

The aim of the first study was to describe what consequences corporatization and privatization of healthcare may have for the work climate for a specific profession (physicians). The study compared the experiences of work climate between physicians working in three hospitals: one that had been corporatized, one that had been privatized and one that had remained a publicly administered unit.

Method

Through questionnaires, the physicians at the three hospitals were asked about their work climate. Comparisons between the physicians at the three hospitals were carried out using multivariate analysis of variance (MANOVA) in which the type of ownership (public administration-run, corporatized or privatized) was the independent variable and the work climate (role stress, job characteristics, leadership and organizational climate) the dependent variables.

Results

The results showed that there was an overall difference in work climate for the physicians at the three hospitals. These differences were found especially in leadership and organizational climate. Overall, the physicians at the privatized and the corporatized hospitals saw the leadership at their respective hospitals as more employee-oriented and change-oriented, and more production-oriented at the privatized hospital compared to the physicians at the public administration-run hospital. With regard to organizational climate, there was a perception of more organizational justice and trust at the privatized and corporatized hospitals than at the public administration-run hospital. The attitude towards privatization was more positive at the privatized hospital compared with the public administration-run hospital. No differences were found between the physicians at the three hospitals with regard to role stress. Concerning job characteristics, it was only job challenge that was reported as higher in the privatized and corporatized hospitals compared with the public administration-run hospital.

Conclusion

In all cases where differences were found, the physicians at the corporatized and privatized hospitals reported more positive experiences of their work climate. This suggests that privatization and corporatization does not need to have a negative impact for the personnel and that these changes may even have beneficial effects for employees' work climate, at least when it comes to physicians.

Study II: How are employees at different levels affected by privatization? A longitudinal study of two Swedish hospitals

Background

Privatization is a form of organizational change that may involve uncertainty and stress for the employees (A. Nelson et al., 1995). This uncertainty is probably linked to the extent of control that employees can possibly exert over the process of change. This, in turn, probably depends on their hierarchic level in the organization. This study is based on the assumptions that employees at lower hierarchic levels have the least access to the resources necessary to cope with uncertainty and are therefore likely to experience the most negative consequences; that employees at an intermediate hierarchic level have access to more resources and therefore

experience less negative consequences; and that employees at the highest hierarchic level have the most access to resources and thus is the group that has the least risk of experiencing the negative consequences that the uncertainty of privatization might denote.

Aim

The aim of the second study was both to examine how healthcare employees are affected by privatization and to enhance the understanding of what privatization can imply for employees with different social status. The study investigated how work-related attitudes and ill-health changed for different hierarchic levels (physicians, registered nurses and assistant nurses) in connection to the privatization of an acute care hospital. The results were compared with a public administration-run acute care hospital that had not undergone any change in ownership.

Method

This study was based on surveys of physicians, registered nurses and assistant nurses who worked at a hospital that was privatized in 1999 and the responses from identical positions at a public administration-run hospital. The questionnaires were answered in 1998 and 2001/2002. Using multivariate analyses of variance (MANOVA) of gain scores (the difference between Time 2 and Time 1 for each variable), the main and interactive effects of the independent variables—type of hospital (privatized or public administration-run) and hierarchic level (physician, registered nurse, assistant nurse)—were analyzed for the dependent variables consisting of work attitudes (job satisfaction, organizational commitment, turnover intentions) and strain (mental and physical health complaints and emotional exhaustion).

Results

A significant main effect of hospital type was shown but, on closer analysis, this effect only consisted of small differences in development between the two hospitals in organizational commitment and physical health complaints. Also, the main effect of hierarchic level was significant but the only difference between the occupational groups (when type of hospital was not taken into consideration) consisted of increased turnover intention for the physicians, almost unchanged turnover intention for registered nurses and decreased turnover intention for assistant nurses. In contrast, four out of six univariate interaction effects were significant. These interaction effects showed that the registered nurses at the privatized hospital reported less job satisfaction and greater turnover intention after privatization, while the opposite development took place for registered nurses at the public

administration-run hospital. For the physicians at the privatized hospital, the work-related attitudes and strain remained basically unchanged between the two study sessions, while there was a deterioration of the attitudes and increased strain for physicians at the public administration-run hospital. For the assistant nurses, there were no major changes in work-related attitudes or strain at any of the hospitals.

Conclusion

While previous studies have demonstrated the negative effects of privatization (Ferrie et al., 1998, 2001; A. Nelson et al., 1995), this study showed no major differences in the development of work related attitudes or strain between a privatized hospital and one that was public administration-run when the results were analyzed for all hospital staff on a whole. However, the study identified differences between the hospitals when the development was divided into hierarchic levels. The middle group (i.e., registered nurses) was the occupational group who reported deterioration in terms of work-related attitudes after the privatization, suggesting that privatization may have the most negative consequences for employees on an intermediate level. In contrast, the results suggest that privatization does not necessarily pose any major consequences on employees at high (physicians) or low (assistant nurses) levels.

Study III: Gender differences in physicians' psychological climate, work-related attitudes and health

Background

Previous research on women's and men's health has often not taken into account the segregated labor market where women and men work in different sectors and at different levels within organizations. Differences in health, but also in the psychological climate and work-related attitudes, could be attributed to women and men having different working conditions, rather than gender differences. Some studies have found that there are no gender differences, for example, with regard to the control experienced between women and men at the same level in an organization (Torkelson & Muhonen, 2003). Other studies have shown that women's and men's situations do differ even when they are working at a similar level (Lundberg & Frankenhaeuser, 1999; Torkelson et al., 2007). This could be due to the lower social status of women (Ridgeway, 1991) who therefore have higher demands to show their competence (Pugh & Wahrman, 1983) while also

having less access to resources such as influence and power (Miller & Clark, 2008).

Aim

The aim of this study was to examine if the psychological climate, work-related attitudes and ill-health differs between women and men who work within the same occupation (physicians) and at the same acute care hospital after a corporatization. In addition, an investigation into whether the psychological climate was perceived differently by women and men, if the levels of psychological climate differed between women and men, and if there were differences in the factors in the psychological climate that were important for women's and men's work-related attitudes and ill-health was undertaken.

Method

All of the physicians at the acute care hospital that had been corporatized in 2000 were surveyed by questionnaires on psychological climate, work-related attitudes and ill-health. The psychological climate was composed of five dimensions (job, role, workgroup, leadership and organizational characteristics) of which each dimension consisted of three variables (except workgroup, which consisted of two variables). First, confirmatory factor analyses were performed for women and men where different parameters were constrained in different steps to investigate whether the factor structures of the psychological climate for women and men differed. Thereafter, a multivariate analysis of covariance (MANCOVA) was performed where the average for women and men were compared in terms of psychological climate, work-related attitudes and ill-health after controlling for potential status factors such as organizational tenure, supervisory position and employment contract. Using a regression analysis, work-related attitudes and ill-health were predicted from psychological climate with the same control variables as in the analysis of variance.

Results

The results of the confirmatory factor analyses showed that neither the factor variances/covariances nor the error terms differed between the genders. However, what differed between women and men were the factor loadings, where the factor loadings for women were lower in some areas (autonomy, role conflict, relation-oriented leadership, organizational justice and organizational trust) compared to men. These differences were taken into account in further analysis, together with the other control variables. The multivariate covariance analysis (MANCOVA) showed, in terms of workgroup characteristics, that the women reported poorer workgroup

climate than the men. On the other hand, the experiences of the job, role, leadership and organization did not differ between the genders. When it came to work-related attitudes, women reported less commitment than men, while there were no differences in job satisfaction or intent to stay in the organization. With regard to ill-health women reported more mental and physical health complaints than men. The regression analysis showed that role characteristics (i.e., role stress) were associated with negative attitudes and more ill-health for women. Also for men, role stress was associated with less job satisfaction and more mental health complaints. However, the workgroup was a resource that was related to better job satisfaction and less ill-health only for men. Organizational characteristics were also associated with more positive work attitudes for men but not for women.

Conclusion

Following an organizational change in the form of corporatization, it was found that although women and men worked in the same hospital, at the same occupation and after consideration had been given to differences in psychological climate, organizational tenure, supervisory position and employment contract, all of the differences that remained between the genders were to the detriment of women. The psychological climate did not seem to contribute to positive work attitudes and less ill-health for women in the same manner as it did for men. This suggests that women physicians have a more disadvantageous situation than men physicians. This could be related to women having lower social status and greater demands put on them, with fewer resources to meet these demands compared with men.

Discussion

The overall aim of the thesis has been to investigate what consequences two forms of organizational change—corporatization and privatization—may have for healthcare employees' work climate, work attitudes and ill-health. Particular attention was devoted to study if such outcomes may vary depending on employees' social status in terms of hierarchic level (physicians, registered nurses, assistant nurses) and gender.

Previous research has shown that organizational changes in general (Ashford, 1988; Gersick, 1991; Paulsen et al., 2005), and more specifically privatization (Ferrie et al., 1998, 2001; A. Nelson et al., 1995), are associated with deteriorated work climate, more negative work-related attitudes and poorer health. Nevertheless, the consequences of privatization and corporatization for employees are in many ways yet unexplored, which is remarkable given how many such changes have been carried out in Sweden and all over the world (Berg, 1999; Megginson & Netter, 2001).

Many studies indicate that access to resources and the ability to exercise control are relevant to the consequences organizational change may have on personnel (Bordia et al., 2004; Martin et al., 2006). Resources and control are aspects that are not evenly distributed within organizations, but are associated with the employee's social status (Henry, 2005). The meaning of social status for the consequences of organizational change has not been investigated to any great extent and even lesser in the context of corporatizations and privatizations. More knowledge is thus needed on what impact various status characteristics may have for employees when these types of organizational changes occur.

Difference in ownership and the consequences for employees

The objective of the first study was to describe what consequences corporatization and privatization of healthcare may have for the work climate for a specific occupation (physicians). The study compared the work climate between physicians who worked in three acute care hospitals: one that had been corporatized (Danderyd's Hospital), one that had been privatized (St Görans Hospital) and one that had remained a public administration unit (Södertälje Hospital).

The study showed that there was an overall difference in work climate for the physicians at the three hospitals. The differences that emerged were particularly found in leadership and organizational climate. Leadership in the corporatized and privatized hospitals was perceived to be more employee-, and change-oriented, and in the privatized hospital also more production-oriented, compared with the public administration unit. Also, parts of the organizational climate, such as trust and justice, were perceived more positively by the physicians in the corporatized and privatized hospitals. However, there were no differences in the experience of role stress between the physicians at the three hospitals, nor did the experiences of the job characteristics differ to any great extent.

One possible explanation for the higher ratings of the leadership at the hospitals that had undergone changes in ownership is that corporatization and privatization imply that hospitals are more autonomous and can act as units independent of the county council (Aidemark, 2004; Öhrming & Sverke, 2001). This may, in turn, contribute to the leadership being perceived as more clear by the employees since the chain of command would seem more transparent. Other studies have also shown that leadership can be perceived as more positive at corporatized hospitals compared to public administration units (Falkenberg et al., 2004; Wallenberg, 2001). The higher levels of trust and justice, as reported in the corporatized and privatized hospitals, fit into this pattern and probably reflect the physicians' perception that the managers had the authority and autonomy necessary to implement what they promised. Previous studies have also shown that the immediate leadership may be perceived as more positive after an organizational change (Olson & Tetrick, 1988) which may be related to the leadership being more active during a change.

It is possible that the physicians—an occupational group at a high hierarchic level and who, to some extent, may have a function as agents of change—perceived corporatization and privatization more positively than employees at lower hierarchic levels. The type of ownership was not relevant to the physicians' perception of job characteristics (with the exception of job challenge) or for their role stress, which could be related to the duties of the physicians being similar regardless of type of ownership (cf. Öhrming, 2008). That role stress does not always increase with a change has also been shown in other studies (Olson & Tetrick, 1988; Shaw et al., 1993).

The importance of social status in the form of hierarchic level

The second study aimed both to examine how healthcare employees can be affected by privatization and to increase the understanding of what privatization could imply for employees with different social status.

Therefore, how work-related attitudes and strain changed for different hierarchic levels (physicians, registered nurses, assistant nurses) was studied in connection with the privatization of an acute care hospital. The results were compared with a public administration-run hospital that had not undergone any change in ownership.

In light of previous studies of organizational change in general (Ashford, 1988; Bordia et al., 2004; Gersick, 1991; Paulsen et al., 2005), and privatization more specifically (Ferrie et al., 1998, 2001; A. Nelson et al., 1995), which have demonstrated negative consequences for employees, it was assumed that privatization was associated with more negative work-related attitudes and more strain. Furthermore, it was assumed that such deterioration would be the worst for employees at the lowest hierarchic levels since this occupational group (assistant nurses) had the least access to resources and therefore less opportunity to participate in decision making, less access to information and fewer possibilities to exercise control over the change. This deterioration was assumed to be lesser for employees in the middle hierarchic level (registered nurses) and the least for employees on the highest hierarchic level (physicians).

Contrary to what was, expected, this study showed no major differences in the development of work-attitudes or strain between the hospital that was privatized and the public administration-run hospital when all hospital personnel were analyzed as a whole. This could be because the privatization investigated in this study came as a logical consequence of the already implemented corporatization. The hospital had sufficient time to plan for the change and did not have to implement any major downsizing in connection with the privatization. Previous studies of how privatization affects staff have, in many cases, focused on privatizations that involved extensive staff reductions (Ferrie et al., 1998, 2001; A. Nelson et al., 1995). That downsizing is associated with negative consequences for employees, with regard to work-related attitudes and health, is well established (Isaksson et al., 2000; Kozlowski et al., 1993; Vahtera & Kivimäki, 1997). However, it is unclear what impact the demands for higher efficiency and profits, which should mean a greater workload, have on the employees in the long-term. It is possible that adverse health effects will take longer to develop than the two years that was this study's time for the follow-up measurement (cf. Zapf, Dormann, & Frese, 1996).

Although privatization in this study did not imply any extensive downsizing, it was nevertheless a privatization that took place where the publicly owned stock company was bought by a private company and where profitability and expansion became priorities on the hospital's agenda (Öhrming, 2008). What this would mean for employees was probably a factor leading to uncertainty. When the development of the hospitals was analyzed based on the employees' status in terms of hierarchic level, it showed that level was important for how the employees' work-related

attitudes and strain changed with privatization, even though it was not entirely in line with the assumptions.

As to the highest hierarchic level—physicians—the assumption was that privatization would be associated with the least negative impact thanks to greater access to resources and opportunities for control (cf. Ashford, 1988; Bordia et al., 2004; Olson & Tetrick, 1988). It can be said that this assumption was met in that there were no substantial changes in terms of work-related attitudes or strain of the physicians at the privatized hospital. This could be associated with the fact that this group had sufficient access to resources, such as information and opportunity to participate in decision-making, to feel enough control over the change. This would thus strengthen the notion that high social status within an organization may be relevant in order to handle a situation that poses new demands, such as an organizational change in form of a privatization. It should be mentioned that while the levels of work-related attitudes and strain of the physicians at the privatized hospital was relatively stable, attitudes deteriorated and strain increased rather dramatically for the physicians in the public administration-run hospital, which demonstrates the difficulty of comparing processes for groups in a complex reality (cf. Cook & Campbell, 1979).

The assumption that privatization would imply the most negative consequences for employees at a low hierarchic level—assistant nurses—was not supported since neither the attitudes nor strain changed very much for the employees at this level. This contradicts previous studies that have shown that organizational change in general (Armstrong-Stassen, 1998; Henry, 2005; Hunsaker & Coombs, 1988; Martin et al., 2006) and also privatization specifically (A. Nelson et al., 1995) may be associated with much uncertainty and little control for employees at a low hierarchic level. The combination of high uncertainty and little control could be expected to result in negative consequences for this group of employees. One explanation for why this was not the case in this study could be that privatization did not affect the immediate work situation for employees at a low hierarchic level to any great extent. Previous studies have shown that, in some cases, organizational changes do not have great implications for employees at a low hierarchic level, resulting in changes not having any major consequences, either positively or negatively for this group of employees (Swanson & Power, 2001; Tienari, 1999).

Work-related attitudes worsened for employees at intermediate hierarchic levels—registered nurses—with privatization. That this group showed the most negative consequences of privatization differed from the assumption that the consequences would be less negative for this group compared with employees at a lower level since the intermediate level should have access to more resources than employees at the lower level (cf. Ashford, 1988; Bordia et al., 2004). The discrepancy could have to do with the middle group being more affected by privatization than the lower hierarchic levels but not having similar resources and access to control as the employees at the highest

hierarchical levels. According to this study, it was therefore the intermediate hierarchical level that was most vulnerable with a privatization. The difficulties of being at an intermediate level have been noted in connection with studies of middle managers (e.g., Armstrong-Stassen, 2005; Ivancevich, Matteson, & Preston, 1982; Swanson & Power, 2001). To be at an intermediate level often involves being subjected to conflicting demands from those who are at higher (e.g., holding down costs) and lower levels (e.g., a reasonable workload). It is possible that with already extensive requirements, accompanied by the new requirements inherent in a privatization, the situation can be experienced as unwieldy and stressful which could lead to more negative work-related attitudes. If the requirements are not compensated for with sufficient access to resources and control to handle the situation, this is especially likely to occur.

The importance of social status in the form of gender

In addition to different reactions to change based on hierarchical levels, differences in status in the form of gender could also have implications in the context of change. The third study's objective was therefore to study if the psychological climate, work-related attitudes and ill-health differed between women and men who worked within the same occupation (physicians) and at the same acute care hospital that had undergone corporatization. The study examined, after controlling for organizational tenure, supervisory position and employment contract, if the psychological work climate was perceived differently by women and men, if the levels of psychological climate differed between women and men, and if there were differences in the factors of the psychological climate which were important for women's and men's work-related attitudes and ill-health.

The results of the confirmatory factor analyses showed that the strength of the factor loadings differed between the genders in terms of autonomy, role conflict, relation-oriented leadership, organizational justice and organizational trust. This suggests that psychological work climate can take on partly different meaning for women and men, in that the aspects that were most central for the respective climate dimensions differed between the genders. The results show that it may be relevant to take into account the importance that women and men attach to different aspects when the psychological climate is compared between the genders. That the meaning that is added to the same concept may differ, either between groups or over time, has been noted previously (Cook & Campbell, 1979; Golembiewski, 1986; Westlander, 2007). This has been a reason why questionnaires have been criticized as a method to examine differences between women and men (Alvesson & Billing, 1997). The risk that the meaning of concepts varies when groups are compared shows the importance of examining and possibly controlling for differences in measurement models.

Regarding comparisons of mean values of psychological climate, the study showed that women reported a poorer workgroup climate, while there was no difference between the genders in how they perceived their job, their role, leadership or organization. When work-related attitudes were compared, women reported less commitment to the organization than men. On the other hand, levels of job satisfaction or intention to stay in the organization did not differ between the genders. With regard to ill-health, women reported more mental and physical health complaints than men. Thus there were similarities and differences between the genders, but all of the differences that emerged were to the detriment of women; this despite the fact that women and men had the same occupation, worked at the same acute care hospital and even after the control of differences in factor loadings in the psychological climate as well as for differences in organizational tenure, supervisory positions and employment contract. Therefore, this study, conducted after the hospital had undergone a corporatization shows that there may be gender differences after an organizational change even when women's and men's situation (i.e., occupational level and organization) is somewhat comparable. This illustrates the need to observe the situation where women and men find themselves in and to not assume that women's and men's situations are the same even though they have the same occupation and work in the same organization.

There were also differences in the importance that psychological climate had for women's and men's work-related attitudes and ill-health. Role stress was associated with negative attitudes and more ill-health for both women and men. For men, however, the workgroup and the organization constituted resources that contributed to more positive attitudes and, to some extent, less ill-health, which was not the case for women.

Since this study showed both similarities and differences between the genders, the results from previous studies showing that women and men may differ even when they work in the same position were confirmed (Frankenhaeuser et al., 1989; Lundberg & Frankenhaeuser, 1999; Torkelson et al., 2007) along with studies that have shown that there is no great difference between the genders when level has been taken into account (Emslie et al., 1999; Liu et al., 2008; Torkelson & Muhonen, 2003). However, it was clear that all the differences that emerged were to the detriment of women. One possible interpretation of these findings is based on the differences in social status between women and men. That status differences exist between the genders has been observed in many different contexts (D. Bergman et al., 2009; Ridgeway, 1991, 2001; Ridgeway & Bourg, 2004; Rothman, 2002; Pugh & Wahrman, 1983) as well as that social status is closely related to access to resources and opportunities for control (Adler et al., 1994; Geyer et al., 2006; Lynch et al., 2000; Marmot, 2004). It is therefore possible to assume that, because of different social status, women and men have different levels of access to resources and opportunities for control (cf. Ridgeway, 1991; Ridgeway & Correll, 2004;

Pratto & Walker, 2004). These are factors that are important in order to manage an occupation that has high demands, such as being a physician (Arnetz, 2001; Simpson & Grand, 1991), but become especially important when an organization has undergone a change that imposes additional demands, as a corporatization might.

It is not just resources that may differ between the genders; the requirements for women and men can also vary. That women need to perform better than men to be judged as equally competent is a finding that has emerged in several studies (Frankenhaeuser et al., 1989; Karambayya, 1998; Muhonen, 1999; Pugh & Wahrman, 1983). Evaluations of the medical profession, in both studies and doctoral theses, suggest the requirements imposed on women and men physicians differ (D. Bergman et al., 2009; Eriksson, 2003; Fridner, 2004; Koninck, Bergeron, & Bourbonnais, 1997; Risberg, 2004; Riska, 2001; West, 1993). Higher job demands combined with greater responsibility for unpaid work (Frankenhaeuser et al., 1989; Lundberg, 1996; Lundberg & Frankenhaeuser, 1999) could imply that women have more demands on them and therefore a higher total workload than men working in comparable positions. As a result of women's lower social status, these requirements are likely not accompanied with the same resources for women as for men (Ridgeway & Correll, 2004) and therefore not with the same opportunity to handle the requirements, which could be an underlying cause of the women experiencing a poorer workgroup climate, less commitment and more ill-health than men in this study.

Methodological considerations

The results from this thesis should be interpreted with some limitations in mind. The analyzed data were self-reported and collected using one method (i.e., questionnaires). There are potential problems with both of these aspects. Self-reported data do not capture an objective reality exceptionally well (Spector, 1994). This thesis, however, focused on how the employees experienced their psychological work climate, their work-related attitudes and their health. With this aim, self-reported data can be relevant sources of information (Spector, 2006). To gather data using only one method does risk that a certain proportion of the variance between the constructs may be due to the method—the so-called mono-method bias—which could lead to the strength of the associations being exaggerated (Campbell & Fiske, 1959). Although the risk of this bias has been suggested to be somewhat overestimated (Spector, 2006), the use of multiple methods could have provided a more comprehensive picture of the issues in this thesis. For example, interviews with employees could have provided more information on how they experienced their work situation and how they were affected by the changes that took place in the organization. Employees' self-reported health could also have been supplemented by more objective data, such as

physiological health markers or number of sick leave days. Economic data from different business ratios could also have given an indication of the demands placed on the different hospitals, and wage levels could have served as an indication of the similarities and/or differences in rewards between different hospitals, different hierarchic levels and between the genders. To complement the surveys with more data sources is something that hopefully can be done in future studies when the effects of privatization and corporatization are further studied.

This thesis deals with change in organizations. A fascinating, but also cumbersome characteristic of change is that it implies movement—from one state to another—and as with all forms of movement, it is difficult to capture and measure. Most available data collection methods can capture only a static picture, while the change is what is taking place between the times when the data collection takes place (Bullock & Batten, 1985; Tsoukas & Chia, 2002). However, there are additional difficulties when studying change. One practical difficulty involves getting to know about an organizational change before it begins and thus affect the staff, which probably explains why organizational change is often analyzed with cross-sectional studies. This is the case in two of the studies in this thesis. Study I has primarily a descriptive function that was intended to give an understanding of how the work climate may appear in three hospitals where two of the hospitals had changed ownership and become corporatized and privatized, while the objective of Study III was primarily to compare women's and men's situations after an organizational change in the form of corporatization. Cross-sectional studies play an important role in identifying, comparing and demonstrating various relationships (Spector, 1994). Study II in this thesis, which examines the impact of privatization on employees at different hierarchic levels, was a longitudinal study and the combination of cross-sectional and longitudinal studies have been highlighted as a way to give a clear picture of a phenomenon (Spector, 1994).

Another difficulty with studying change is the time aspect. There is always a risk that the results would have been different if the time for data collection had been closer to or further from the actual change (cf. Zapf et al., 1996). This applies whether the design is cross-sectional or longitudinal and is a general problem for most studies on organizational change. When analyzing organizational change, longitudinal studies have the advantage in that there exists a baseline (L. R. Bergman & D. Magnusson, 1990; Taris, 2000). Longitudinal studies are thus an opportunity to follow a development but, despite this, the problem of causality is not avoided—the difficulty of determining whether the outcome actually depends on the organizational change or if it results from other factors still remains (cf. Cook & Campbell, 1979). Since it can never be ruled out that other factors affect a dependent variable other than possibly in strict controlled laboratory experiments, which in turn bring other problems, such as generalizing to the “natural world”—it means that each study can only comment on the relationship

before and/or after a change. However, it is not possible to say with certainty what exactly is due to the change itself. To follow a comparison organization, as in Study II, may give an indication of how the development would have been if an organizational change would not have taken place, but this is obviously difficult to comment on when it comes to such complex organizations as hospitals. For example, an event beyond the control of the study most certainly appears to have happened to the physicians at the comparison hospitals in Study II that lead to deteriorating work-related attitudes and increased strain for this group. However, a cumulative view of knowledge means, that a sufficient number of studies together can provide a reasonably reliable picture of the consequences of different types of organizational change. This shows the importance of continuing to study the consequences of corporatizations and privatizations for employees.

Additionally, an aspect that should be included when interpreting the results of this thesis is that the organizations studied here have certain characteristics that may have influenced the outcomes. All three hospitals were located in the Stockholm area, which is one of the regions in Sweden that has long been far ahead in introducing market adapted operating systems within healthcare (Öhrming, 2008). In spite of all hospitals being situated in the area of the Stockholm County Council, the hospitals served in different sub-areas which could affect the make-up of patients, which in turn could have implications for the work situation of the employees. Another specific characteristic is that St. Göran's Hospital was the first acute care hospital to be corporatized in Sweden and one of the first that was privatized, and the fact that the effects of the privatization in general did not become more negative could be attributed to the media attention that this change received. The high media interest for the hospital may have meant that the employees felt they were being attended to and that the organization was perceived as modern and successful (cf. the Hawthorne effect; Roethlisberger & Dickson, 1939/1967).

It is also possible that the healthcare employees who were positive towards privatization had sought out the privatized St. Göran's Hospital, while those who disliked this change applied to other hospitals. The same could apply for Danderyd's Hospital, which was corporatized. There were, however, very few people who declined to be transferred after the change in ownership, which reduced the risk of impact on the results of such a selection.

There is always a risk, however, that the attrition that occurs is inherently systematic, affecting the results (L. R. Bergman & D. Magnusson, 1990). In Study I, it was shown that those who constituted the effective sample had worked slightly longer and were somewhat older compared with the group who were not included in the analysis because of internal attrition, which may have affected the outcome. In Study III, no non-response analysis was performed but in the non-response analysis conducted in Study II, differences emerged between those who had left the hospital at the time of

the second data collection and the effective, longitudinal sample which could mean that those who were most dissatisfied had left the hospital. On the other hand, there were hardly any differences between the effective longitudinal sample and those who remained with the hospitals but who chose not to respond at the second data collection. This suggests that the responses were representative of the longitudinal sample, i.e., those who had worked in the hospitals during the time of the study. That the pattern of attrition was similar in the two hospitals reduces the risk that the comparison of hospitals was affected by the attrition. However, the sampling of both hospitals may be biased by the tendency for those in better health having a better chance of staying employed and therefore being included in data collections, which is something that probably applies to most organizations. The occurrence of attrition and the difficulty of excluding that it may be systematic imply that generalizations still must be done with caution.

It is also possible that the experience of corporatization and privatization within activities related to healthcare differs from how personnel experience such changes in other activities. The streamlining and profit requirements that privatization and, to some extent, corporatization strive for could be perceived as more conflicted within healthcare activities compared to businesses where work is not related to people in a similarly direct way. It is therefore essential to also study the consequences of corporatization and privatization for employees in other business areas.

It should also be noted that the cases of corporatization and privatization that have been studied in this thesis have been with regard to the production aspect, which is one of several functions that can be corporatized or privatized. The consequences for the employees could vary if other functions, such as financing or regulation of an activity, were corporatized or privatized. It is also possible that if the production, financing and regulation were corporatized or privatized at the same time the impact would be more dramatic since that means that the degree of competition would be larger, which increasing the risk that more extensive changes would have to be implemented. The aspects that have been privatized are therefore essential to clarify. It is possible that studies of privatization that have shown more negative consequences for employees have included privatization of other or more functions than just the production aspect.

Another question that arises concerns the issues faced when dividing people into categories based on gender and hierarchic level when these categories contain so many different life situations. To categorize people based on gender has been criticized on the basis that it is not an easily accessible and straightforward categorization. It has also been argued that the division itself may lead to possible differences between the genders being accentuated (Alvesson & Billing, 1997). The hierarchic levels that were included in this thesis (i.e., physicians, registered nurses, assistant nurses) are in themselves not homogeneous groups but contain employees who have different specializations and access to various formal and/or

informal power structures. Categorizations of people have also been criticized on the basis that it is often people with more power and influence who define the center (i.e., “the norm”) by separating it from the periphery (Spivak, 2001). Against this criticism of categorizations, opinions that categorizations are necessary to show differences in opportunities between groups have been expressed. The ability to identify possible inequalities is a first step to doing something about them (Mohanty, 2001).

Theoretical implications

Corporatization and privatization

The corporatization and privatization studied in this thesis were the result of many external and internal causes of change. These changes in ownership have characteristics of several of the explanatory models for change that van de Ven and Poole (1995) called the “motors of change”. A dialectical model of explanation could serve as a frame for interpretation. Corporatization and privatization, as studied in this thesis, can be seen as the result of a greater conflict between forces that possess different views on whether healthcare should be operated publicly or privately. This conflict led to that the previous system, where the publicly-operated healthcare prevailed universally (Blomqvist, 2005; Öhrming, 2008), was replaced with a greater element of private actors in Swedish healthcare. Corporatization and privatization, in general, could also be interpreted from evolutionary driving forces where one objective of these changes is to have inefficient operations reduced or eliminated by fierce competition (cf. Megginson & Netter, 2001). This could be one explanation for why international studies of privatization have found a negative impact on employees (Ferrie et al., 1998, 2001; A. Nelson et al., 1995). The corporatization and privatization of the acute care hospitals included in this thesis introduced more competition and increased the market economic dynamics in Swedish healthcare (Öhrming & Sverke, 2001). The evolutionary driving force would, however, probably have been stronger if the financing and regulation aspects of the activities were privatized simultaneously.

This thesis has addressed two different perspectives within the dimensions of public and private sectors. The dimensions of public and private can be seen as essentially different; numerous sources in literature demonstrate that private and public sectors have, for example, various objectives, different ways of looking at customers and various platforms for governance (Blomqvist & Rothstein, 2000; Jacobsson, 1993; Perry & Rainey, 1988). One view of the public and private relationship demonstrates that corporatization and privatization are seen as radical changes from one state (public) to another (private). Another perspective involves looking at

public and private sectors as two extremes along a continuum and that most organizations find themselves somewhere between these two end points (Bozeman, 1987; Donahue, 1989).

Other research on organizational change in the form of corporatization and privatization has described these changes as revolutionary from the standpoint that public and private organizations are essentially different (A. Nelson et al., 1995; Öhrming & Sverke, 2001; Rosenberg, 1995). The starting point for this thesis was therefore that corporatization and privatization are major changes that imply significant disruption and thus represent major uncertainty for employees, and as a result show a negative impact on work climate, work attitudes and health. The results of the studies included in this thesis, however, indicate that corporatization and privatization of acute care hospitals do not have to be so incredibly dramatic for the staff and can have continuous, evolutionary aspects. These results suggest that corporatizations and privatizations, at least in some cases, can be seen as a movement along a continuum that does not need to trigger a large amount of negative reactions among the employees (cf. Blomqvist, 2005; Megginsson & Netter 2001).

That the types of organizational change studied in this thesis did not lead to more extensive consequences for employees could be due to the specific cases of corporatization and privatization, which were well planned. Since the corporatization of St. Görans's Hospital, there were plans for the hospital to be privatized and when the change occurred, it may well have been perceived as a natural step for the organization. The hospital that was corporatized (Danderyd's Hospital) had the successful corporatization of St. Göran's Hospital to model itself after (cf. Öhrming & Sverke, 2001), which may also have reduced concerns about this change. As with the privatization of St. Göran's Hospital, the corporatization of Danderyd's Hospital did not usher in any cutbacks where staff had to quit or were let go. Corporatization and privatization as studied in this thesis were not followed by other major changes, such as downsizing, mergers or acquisitions, which previous studies have shown could have negative consequences for staff (R. J. Burke & Cooper, 2000; Cartwright & Hudson, 2000; Kozlowski et al., 1993). With the corporatization and privatization studied in this thesis, only the production aspect of healthcare changed ownership. If a change of ownership is well prepared in acute care hospitals where only the production aspect changes, the consequences do not necessarily need to be negative, at least if only physicians are studied, or if all healthcare workers are studied as a unit.

The importance of social status

Although corporatization and privatization do not necessarily have to be especially dramatic and disruptive, they are organizational changes that may affect employees within the same organization in different ways depending

on their social status. Social status is relevant in the organizational context because it is so strongly associated with access to resources and opportunity to feel a sense of control (Geyer et al., 2006; Henry, 2005) and, although in a more complex way, is linked to demands. Access to resources and the ability to feel a sense of control are important determinants of health in life in general (Marmot, 2004; Wilkinson, 2005), but these factors are perhaps of greatest importance in situations where a person could feel threatened, as with organizational changes (Martin et al., 2005; Shaw et al., 1993). It is particularly critical when a person does not feel that she or he has the resources needed to cope with a situation (cf. Lazarus & Folkman, 1984). Therefore, there is a risk that organizational changes will result in more negative consequences for people with lower social status that have less access to resources, while the risk of adverse effects is less for employees at higher levels who have access to more resources.

The assumption that high social status would be associated with a lower risk of negative consequences during organizational change was consistent as the physicians did not seem to experience any negative consequences in either the corporatization or the privatization. Even if the requirements were high for this group, as a result of the possibility that they had to act as change agents, it seemed that the resources for employees at a high hierarchic level were sufficient to handle these requirements.

Despite the assumption that organizational changes entail negative consequences for employees at a low hierarchic level as they have the least amount of access to resources and the least opportunity to feel a sense of control (Armstrong-Stassen, 1998; Henry, 2005; Hunsaker & Coombs, 1988; Martin et al., 2006), this thesis showed that privatization does not need to involve positive or negative consequences for employees at a low hierarchic level. One reason for this could be that status, in terms of hierarchic levels, is also associated with the extent to which change affects employees. A change that does not concern a specific group of employees does not impose any new demands, poses no threat and implies no increased stress or risk of adverse consequences (cf. Lazarus & Folkman, 1984).

The amount of demands in relation to the availability of resources seems to be relevant to the consequences of organizational changes on employees at an intermediate level. Contrary to what has been assumed, the registered nurses in Study II showed more negative consequences of privatization than employees at lower hierarchic levels. This occupational group was probably affected by the privatization but did not have the same access to resources, in terms of opportunities for participation and influence, as the physicians at the higher hierarchic level.

Requirements in relation to resources may also be relevant to the social status differences within a particular group, such as with physicians (D. Bergman et al., 2009). It has been shown that people with lower social status have to perform better than someone with higher status in order to be considered equally competent (Pugh & Wahrman, 1983; Ridgeway, 1991;

Ridgeway & Bourg, 2004). In the case of women, they also have a greater responsibility for unpaid work than men (Lundberg, 1996; Lundberg & Frankenhaeuser, 1999), which means additional requirements and a larger total workload. That the emergent differences between female and male physicians after a change were to the detriment of women could be related to differences in social status between the genders and subsequently differences in access to resources, control and amount of requirements. It appears that the requirements can be high for people with high and low social status, but the amount of resources and the degree of control available make it easier for people with higher status to cope with the demands that arise.

The amount of demands and resources and how those could vary between different hierarchic levels during an organizational change is, however, not investigated in this thesis but based on theoretical assumptions. It would be interesting to investigate further how those different aspects varied for groups with different social status during organizational change.

The status markers that were studied in this thesis were gender and hierarchic level, which are only two of many status factors. Examples of other aspects of status include ethnicity, age, skin color, background, sexuality, religion, appearance and disability. These are also factors that play a role in how people's lives are shaped and the conditions and resources available to them which have implications for individuals' health and well-being (Eriksson-Zetterquist & Styhre, 2007). None of the above examples exist in a vacuum, and every aspect of status coincides with another. Despite this intersectionality, there is not much research on how combinations of different status factors give rise to different consequences with organizational change. One reason may be that it becomes extremely complex to study combinations of different status factors with variable-oriented methods (L. R. Bergman & D. Magnusson, 1997). One possible way to circumvent this problem might be to use methods based on a person-oriented approach. This approach emphasizes that it is the individual that is the focus for the research. It assumes that each individual consists of a combination of many different variables, and that there are individuals whose combinations are similar (L. R. Bergman & D. Magnusson, 1997). It opens the possibility to study whether individuals with similar combinations of status variables are also similar with regards to consequences of organizational changes, but differ from groups with other combinations of status characteristics. Hopefully, more status elements and the combination of various aspects of status will be highlighted in further studies of organizational change.

A related question surrounds how detailed the division into groups should be from which the consequences of organizational change are studied: analyzing employees divided on hierarchic level or gender gives more information than analyzing all the healthcare professionals together. It could, however, be argued that every individual has their own unique interpretation of an organizational change and to truly understand each individual's

experience of a change, it would be necessary to interview every employee. Such an in-depth interview would be valuable (cf. Gummesson, 2003), but must also be weighed against the ability to generalize to others.

Conclusion

In a changing world, corporatization and privatization are two forms of organizational change whose consequences for staff have yet to be studied to any great extent, despite the frequency of these changes in Sweden and around the world (Berg, 1999; Megginson & Netter, 2001). Corporatization and privatization have been described as potentially highly stressful events (A. Nelson et al., 1995; Öhrming & Sverke, 2001; Rosenberg, 1995), like other organizational changes involving uncertainty and anxiety for the employees (Ashford, 1988; Bordia et al., 2004; Gersick, 1991; Paulsen et al., 2005). The results of this thesis show that these changes do not necessarily imply any particular negative consequence on employees' work climate, work-related attitudes and health. This may be because the examples of corporatization and privatization studied in this thesis were well planned and not followed by other changes, such as downsizing, mergers or acquisitions, but were simply changes of ownership. It is therefore important to plan a corporatization or privatization well and also to take into account what additional organizational changes a corporatization or privatization may imply in order to predict the extent of the consequences of a change in ownership for employees.

Although these changes were not very extensive, there were still groups who were more vulnerable than others. The advantage of high social status in terms of creating better access to resources and the possibility to feel a sense of control seems to counteract uncertainty throughout either the corporatization or privatization process. For employees on a low hierarchic level who probably were not particularly concerned with the change, the consequences do not seem to be particularly negative. Employees whose work situation is affected by a change effort but still do not have enough resources to handle the requirements associated with an organizational change may experience negative consequences. This may apply to those at an intermediate level, such as the registered nurses that were investigated in the privatization in Study II. Women physicians also seem to have a worse situation than men physicians after a corporatization, which could be due to the fact that even if women and men have the same occupation, women's social status is still lower, which the results in Study III suggest. Social status thus seems to be an important factor to consider in order to better understand the consequences of privatization and corporatization and employees' experiences of their work situation in general. In future studies, another relevant view to take into account involves the extent to which different groups' work situations are actually affected by an organizational

change as well as in what way demands and resources change for groups with different social status.

People will continue to form organizations and organizations will continue to change due to external and internal factors. Organizational change involves uncertainty about the future because the change implies ignorance of what is coming next. Many people may experience organizational change as threatening. To meet organizational changes in a way that reduces uncertainty and the sense of threat is of interest to the employees, managers, policy makers, and—in healthcare—patients and their relatives. Having access to resources and a feeling of control seem to be key factors that are important to be able to handle organizational change without negative consequences. Difference in social status is one way to explain that the access to resources can vary. The awareness that organizational change may lead to different consequences for those with different social status is a good starting point to understanding the problems of pursuing changes in organizations and to successfully implementing organizational changes, while reducing the risk of negative consequences for the employees.

References

- Acker, J. (1990). Hierarchies, jobs, bodies: A theory of gendered organizations. *Gender and Society*, 4(2), 139-158.
- Adler, N. E., Boyce, T., Cohen, C. S., Folkman, S., Kahn, R. L., & Syme, S. L. (1994). Socioeconomic status and health: The challenge of the gradient. *American Psychologist*, 49(1), 15-24.
- Adler, N. E., Epel, E. S., Castellazzo, G., & Ickovics, J. R. (2000). Relationship of subjective and objective social status with psychological and physiological functioning: Preliminary data in healthy white women. *Health Psychology*, 19(6), 586-592.
- Adler, N. E. & Rehkopf, D. H. (2008). U.S. disparities in health: Descriptions, causes, and mechanisms. *Annual Review of Public Health*, 29, 235-252.
- Ahrne, G. (1994). *Social organizations: Interaction inside, outside and between organizations*. London: Sage.
- Aidemark, L-G. (2004). *Sjukvård i bolagsform: En studie av Helsingborgs Lasarett AB och Ängelholms Sjukhus AB*. [Healthcare with corporatized ownership: A study of Helsingborg Hospital AB and Ängelholms Hospital AB]. Växjö, Sweden: Växjö University Press.
- Aidemark, L-G. (2005). Ekonomistyrning i sjukvården: En jämförelse mellan sjukhusbolag och förvaltningssjukhus. [Financial control in healthcare: A comparison between hospitals that are publicly owned stock companies and hospitals run as administration units]. *Nordiske Organisationsstudier*, 7(2), 58-76.
- Aiken, L. H., Sloane, D. M., & Sochalski, J. S. (1998). Hospital organization and outcomes. *Quality in Health Care*, 7, 222-226.
- Alvesson, M. & Billing, Y. D. (1997). *Understanding gender and organizations*. London: Sage.
- Alvesson, M. & Deetz, S. (2005). Critical theory and postmodernism: Approaches to organizational studies. In S. R. Clegg & C. Hardy (Eds.), *Studying organizations: Theory and methods* (pp. 185-211). London: Sage.
- Armenakis, A. A., & Bedeian, A. G. (1999). Organizational change: A review of theory and research in the 1990s. *Journal of Management*, 25, 293-314.
- Armstrong-Stassen, M. (1998). The effect of gender and organizational level on how survivors appraise and cope with organizational downsizing. *Journal of Applied Behavioral Science*, 34, 125-142.
- Armstrong-Stassen, M. (2005). Coping with downsizing: A comparison of executive-level and middle managers. *International Journal of Stress Management*, 12, 117-141.
- Arnetz, B. B. (2001). Psychosocial challenges facing physicians of today. *Social Science and Medicine*, 52, 203-213.
- Ashford, S. J. (1988). Individual strategies for coping with stress during organizational transitions. *Journal of Applied Behavioral Science*, 24, 19-36.

- Ashford, S., Lee, C., & Bobko, P. (1989). Content, causes and consequences of job insecurity: A theory-based measure and substantive test. *Academy of Management Journal*, 32, 803-829.
- Bailey, J. (2000). Some meanings of "the private" in sociological thought. *Sociology*, 34(3), 381-401.
- Beall, A. Eagly, A. H., & Sternberg, R. J. (2004). Introduction. In A. H. Eagly, A. E. Beall, & R. J. Sternberg (Eds.), *The Psychology of Gender* (pp. 1-8). New York: Guilford Press.
- Beehr, T. A., Walsh, J. T., & Taber, T. D. (1976). Relationship of stress to individually and organizationally valued states: Higher order needs as a moderator. *Journal of Applied Psychology*, 61, 41-47.
- Berg, A. (1999). *Staten som kapitalist: Marknadsanpassningen av de affärsdrivande verken 1976-1994* [The state as a capitalist: The commercialization of utilities 1976-1994]. Doctoral thesis, Uppsala University: Department of Government.
- Bergman, L. R., & Magnusson, D. (1990). General issues about data quality in longitudinal research. In D. Magnusson & L. R. Bergman (Eds.), *Data quality in longitudinal research* (pp. 1-31). Cambridge: Cambridge University Press.
- Bergman, L. R., & Magnusson, D. (1997). A person-oriented approach in research on developmental psychopathology. *Development and Psychopathology*, 9(2), 291-319.
- Bergman, D., Stotzer, E., Wahlström, R., & Sandahl, C. (2009). Learning from dialogue groups: Physicians' perceptions of role. *Journal of Health, Organization and Management*, 23(2), 225-239.
- Bishop, M., Kay, J., & Mayer, C. (1994). *Privatization and economic performance*. Oxford: Oxford University Press.
- Blake, R. R., & Mouton, J. S. (1969). *Building a dynamic corporation through grid organization development*. Reading, MA: Addison-Wesley.
- Blomqvist, P. (2004). The choice revolution: Privatization of Swedish welfare services in the 1990s. *Social Policy & Administration*, 38(2), 139-155.
- Blomqvist, P. (2005). Privatisering av sjukvård: Politisk lösning eller komplikation? [Privatization of healthcare: Political solution or complication?] *Socialvetenskaplig tidskrift*, 2-3, 169-188.
- Blomqvist, P., & Rothstein, B. (2000). *Välfärdsstatens nya ansikte: Demokrati och marknadsreformer inom den offentliga sektorn*. [The new face of the welfare state: Democracy and market reforms in the public sector]. Stockholm: Agora.
- Bordia, P., Hunt, E., Paulsen, N., Tourish, D., & DiFonzo, N. (2004). Uncertainty during organizational change: Is it all about control? *European Journal of Work and Organizational Psychology*, 13, 245-365.
- Bozeman, B. (1987). *All organizations are public: Bridging public and private organizational theories*. San Francisco/London: Jossey-Bass.
- Bozeman B., & Bretschneider, S. (1994). The "publicness puzzle" in organization theory: A test of alternative explanations of differences between public and private organizations. *Journal of Public Administration Research and Theory*, 4(2), 197-223.
- Brunsson, N. (1985). *The irrational organization: Irrationality as a basis for organizational action and change*. Chichester: John Wiley & Sons.
- Brunsson, N. (1989). *The organization of hypocrisy: Talk, decisions and actions in organizations*. Chichester: John Wiley & Sons.
- Brunsson, N., & Olsen, J. P. (1993). *The reforming organization*. London: Routledge.

- Bullock, R. J., & Batten, D. (1985). It's just a phase we're going through: A review and synthesis of OD phase analysis. *Group Organization Management*, 10, 383-412.
- Burke, W. W. (2002). *Organization change: Theory and practice*. Thousands Oaks: Sage.
- Burke, R. J., & Cooper, C. L. (2000). The new organizational reality: Transition and renewal. In R. J. Burke & C. L. Cooper (Eds.), *The organization in crisis: Downsizing, restructuring, and privatization* (pp. 4-18). Oxford/Massachusetts: Blackwell Publishers.
- Burke, R. J., & Nelson, D. (1998). Mergers and acquisitions, downsizing, and privatization: A North American perspective. In M. K. Gowing, J. D. Kraft, & J. C. Quick (Eds.), *The new organizational reality: Downsizing, restructuring, and revitalization* (pp. 21-54). Washington DC: APA.
- Burrell, G., & Morgan, G. (1979). *Sociological paradigms and organizational analysis: Elements of the sociology of corporate life*. Aldershot: Ashgate.
- Campbell, D. T., & Fiske, D. M. (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological Bulletin*, 56, 81-105.
- Cartwright, S., & Hudson, S-L (2000). Coping with merges and acquisitions. In R. J. Burke, & C. L. Cooper (Eds.), *The organization in crisis: Downsizing, restructuring an privatisation* (pp. 269-283). Oxford/Massachusetts: Blackwell Publishers.
- Cavelaars, A. E. J. M., Kunst, A. E., & Machenbach, J. P. (1997). Socioeconomic differences in risk factors for morbidity and mortality in the European Community. An international comparison. *Journal of Health Psychology*, 2, 353-372.
- Chiesa, M. (2005). Modernization or privatization? The future of the NHS and implications of governmental reforms for psychotherapy services. *Psychoanalytic Psychotherapy*, 19(1), 71-85.
- Child, J. (1972). Organizational structure, environment and performance: The role of strategic choice. *Sociology*, 6,(1), 1-22.
- Cohen, S., Doyle, W., & Baum, A. (2006). Socioeconomic status is associated with stress hormones. *Psychosomatic Medicine*, 68(3), 414-420.
- Collins, G. (2005). The gendered nature of mergers. *Gender, Work and Organization*, 12, 270-290.
- Cook, T. D., & Campbell, D. T. (1979). *Quasi-experimentation: Design & analysis issues for field settings*. Boston: Houghton Mifflin Company.
- Corral, A. & Isusi, I. (2005). *Part-time work in Europe*. Dublin: European Foundation for the Improvement of Living and Working Conditions.
- Cunha, R. C. (2000). Impact of privatization in Portugal. In R. J. Burke & C. L. Cooper (Eds.), *The organization in crisis: Downsizing, restructuring and privatisation* (pp. 44-57). Oxford/Massachusetts: Blackwell Publishers.
- Cunha, R. C., & Cooper, C. L. (2002). Does privatization affect corporate culture and employee wellbeing? *Journal of Managerial Psychology*, 17, 21-49.
- Dahlgren, J. (2003). *Effekter av konkurrensutsättning: En kunskapsöversikt* [Effects of competition: An overview]. Linköping University, Sweden: The Department of Economy.
- Danderyd's Hospital AB (2000). Årsbokslut 2000 [Annual report]. Stockholm: Danderyd's Hospital AB.
- Davidson, R., Kizinger, J., & Hunt, K. (2006). The wealthy get healthy, the poor get poorly? Lay perceptions of health inequalities. *Social Science and Medicine*, 62, 2171-2182.

- Deary, I. J., Whiteman, M. C., Starr, J. M., Whalley, L. J., & Fox, H. C. (2004). The impact of childhood intelligence on late life: Following up the Scottish mental survey of 1932 and 1947. *Journal of Personality and Social Psychology*, 86(1), 130-147.
- Dekker, S., & Schaufeli, W. A. (1995). The effects of job insecurity on psychological health and withdrawal: A longitudinal study. *Australian Psychologist*, 30, 57-63.
- Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The Job Demands-Resources Model of burnout. *Journal of Applied Psychology*, 86, 499-512.
- De Vogli, R., Ferrie, J. E., Chandola, T., Kivimäki, M., & Marmot, M. G. (2007). Unfairness and health: Evidence from the Whitehall II study. *Journal of Epidemiology and Community Health*, 61, 513-518.
- Donahue, J. D. (1989). *The privatization decision: Public ends, private means*. New York: Basic Books.
- Earle, J. S. (2009). Mass privatization and mortality: Is job loss the link? *Employment Research*, 16(2), 6-7.
- Egan, M., Petticrew, M., Ogilvie, D., Hamilton, V., & Drever, F. (2007). "Profit before people"? A systematic review of the health and safety impacts of privatising public utilities and industries in developed countries. *Journal of Epidemiological Community Health*, 61, 862-870.
- Ekehammar, B. (1974). Interactionism in personality from a historical perspective. *Psychological Bulletin*, 81(12), 1026-1048.
- Ekvall, G., & Arvonen, J. (1994). Leadership profiles, situation and effectiveness. *Creativity and Innovation Management*, 3, 139-161.
- Emslie, C., Hunt, K., & Macintyre, S. (1999). Problematising gender, work and health: The relationship between gender, occupational grade, working conditions and minor morbidity in full-time bank employees. *Social Science and Medicine*, 48, 33-48.
- Eriksson, K. (2003). *Manligt läkarskap, kvinnliga läkare och normala kvinnor: Kön- och läkarskapande symbolik, metaforik och praktik*. [Physicianship, female physicians and normal women: The symbolical, metaphorical and practical doing(s) of gender and physicians]. Doctoral dissertation, Uppsala University, Department of Sociology. Stehag, Sweden: Förlags ab Gondolin.
- Eriksson-Zetterquist, U., & Styhre, A. (2007). *Organisering och intersektionalitet*. [Organizing and intersectionality]. Malmö, Sweden: Liber.
- Eurostat (2008). *The life of women and men in Europe: A statistical portrait*. Luxembourg: Office for Official Publications of the European Communities.
- Falkenberg, H., Sverke, M., Hellgren, J., & Näswall, K. (2004). Sjukvård på bolag eller i förvaltningsform: Hur påverkas personalen? [Healthcare in a public stock company or in a public administration unit: How are the employees affected?] *Arbetsmarknad & Arbetsliv*, 10, 117-133.
- Ferlie, E., Ashburner, L., Fitzgerald, L., & Pettigrew, A. (1996). *The New Public Management*. New York: Oxford University Press.
- Ferrie, J. E., Martikainen, P., Shipley, M. J., Marmot, M. G., Stansfeld, S. A., & Smith, G. D. (2001). Employment status and health after privatization in white collar civil servants: Prospective cohort study. *British Medical Journal*, 322, 647-651.
- Ferrie, J. E., Shipley, M. J., Marmot, M. G., Stansfeld, S. A., & Smith, G. D. (1995). Health effects of anticipation of job change and non-employment: Longitudinal data from the Whitehall II study. *British Medical Journal*, 311, 1264-1269.

- Ferrie, J. E., Shipley, M. J., Marmot, M. G., Stansfeld, S. A., & Smith, G. D. (1998). An uncertain future: The health effects of threat to employment security in white-collar men and women. *American Journal of Public Health*, 88, 1030-1036.
- Frankenhaeuser, M. (1991). A biopsychosocial approach to work life issues. In J. V. Johnson & G. Johansson (Eds.), *The psychosocial work environment: Work organization, democratization and health* (pp. 49-60). New York: Baywood Publishing Company.
- Frankenhaeuser, M. Lundberg, U., Fredrickson, M., Melin, B., Tuomisto, M., Myrsten, A-L., Hedman, M., Bergman-Losman, B., & Wallin, L. (1989). Stress on and off the job as related to sex and occupational status in white-collar workers. *Journal of Organizational Behavior*, 10(4), 321-346.
- French, W. (1969). Organizational development objectives, assumptions, and strategies. *California Management Review*, 12, 23-34.
- Fridner, A. (2004). *Karriärvägar och karriärmönster bland disputerade läkare och medicinare*. [Career paths in academic medicine]. Doctoral dissertation, Uppsala University: Department of Psychology.
- Gambles, R., Lewis, S., & Rapoport, R. (2006). *The myth of work-life balance: Challenges of our time for men, women and societies*. West Sussex: John Wiley & Sons.
- Garbarski, D. (2010). Perceived social position and health: Is there a reciprocal relationship? *Social Science & Medicine*, 70, 692-699.
- Gersick, C. J. G. (1989). Marking time: Predictable transitions in task groups. *Academy of management Journal*, 32(2), 274-309.
- Gersick, C. J. G. (1991). Revolutionary change theories: A multilevel explorations of the punctuated equilibrium paradigm. *Academy of Management Review*, 16(1), 10-36.
- Geyer, S., Hemström, Ö., Peter, R., & Vågerö, D. (2006). Education, income, and occupational class cannot be used interchangeably in social epidemiology. Empirical evidence against a common practice. *Journal of Epidemiology and Community Health*, 60, 804-810.
- Greenglass, E. R. (1995). Gender, work stress and coping: Theoretical implications. *Journal of Social Behavior & Personality*, 10(6), 212-134.
- Greenwood, R. & Hinings, C. R. (1996). Understanding radical organizational change: Bringing together the old and the new institutionalism. *Academy of Management Review*, 21(4), 1022-1054.
- Greiner, L. E. (1972). Evolution and revolution as organizations grow. *Harvard Business Review*, Jul-Aug, 37-46.
- Griffin, R. W. (1991). Effects of work redesign on employee perceptions, attitudes, and behaviors: A long-term investigation. *Academy of Management Journal*, 34, 425-435.
- Goldberg, D. (1978). *Manual of the General Health Questionnaire*. Windsor: National Foundation for Educational Research.
- Goldberg, D. (1972). *The detection of psychiatric illness by questionnaire*. London: Oxford University Press.
- Golembiewski, R. T. (1986). Contours in social change: Elemental graphics and a surrogate variable for gamma change. *Academy of Management Review*, 11(3), 550-566.
- Gottfredson, L. S., & Deary, I. J. (2004). Intelligence predicts health and longevity, but why? *American Psychological Society*, 13(1), 1-4.

- Gummesson, E. (2003). Fallstudiebaserad forskning [Case studies in science]. In B. Gustavsson (Ed.), *Kunskapande metoder inom samhällsvetenskapen* [Methods for knowledge in social science] (pp. 115-144.) Lund, Sweden: Studentlitteratur.
- Hackman, J. R., & Oldham, G. R. (1975). Development of the Job Diagnostic Survey. *Journal of Applied Psychology*, 60, 159-170.
- Hackman, J. R., & Oldham, G. R. (1976). Motivation through the design of work: Test of a theory. *Organizational behaviour and Human Performance*, 16, 250-279.
- Harrington, C., & Pollock, A. M. (1998). Decentralisation and privatisation of long-term care in UK and USA. *Lancet*, 351(9118), 1805-1809.
- Heller, F., Pusić, E., Strauss G., & Wilpert, B. (1998). *Organizational participation: Myth and reality*. New York: Oxford University Press.
- Hellgren, J., & Sverke, M. (2001). Unionized employees' perceptions of role stress and fairness during organizational downsizing: Consequences for job satisfaction, union satisfaction and well-being. *Economic and Industrial Democracy*, 4, 543-567.
- Hellgren, J., Sverke, M., & Isaksson, K. (1999). A two-dimensional approach to job insecurity: Consequences for employee attitudes and well-being. *European Journal of Work and Organizational Psychology*, 8, 179-195.
- Henry, P. C. (2005). Life stresses, explanatory style, hopelessness, and occupational class. *International Journal of Stress Management*, 12, 241-256.
- Huber, G. P., & Glick, W. H. (1993). Sources and forms of organizational change. In G. P. Huber & W. H. Glick (Eds.), *Organizational change and redesign*, (pp. 3-15). New York: Oxford University Press.
- Hunsaker, P. L. & Coombs, M. W. (1988). Mergers and acquisitions: Managing the emotional issues. *Personnel*, 67, 56-63.
- Isaksson, K., & Johansson, G. (1997). *Avtalspension med vinst och förlust: Konsekvenser för företag och medarbetare* [Early retirement agreement for better and worse: Consequences for companies and workers]. Stockholm: Folksam.
- Isaksson, K., Hellgren, J., & Pettersson, P (2000). Repeated downsizing: Attitudes and well-being for surviving personnel in a Swedish retail company. In K. Isaksson, C. Hogstedt, C. Eriksson, & T. Theorell (Eds.), *Health effects of the new labor market* (pp. 85-101). New York: Plenum.
- Ivancevich, J. M., Matteson, M. T., & Preston, C. (1982). Occupational stress, type A behavior, and physical well being. *Academy of Management Journal*, 25, 373-391.
- Jacobsson, B. (1993). *Reformer och organisatorisk identitet: Sjukvård i förändring*. [Reforms and organizational identity: Healthcare in transition]. Lund University: Institute of Economic Research.
- James L. R., & Sells, S. B. (1981). Psychological climate: Theoretical perspectives and empirical research. In D. Magnusson (Ed.), *Toward a psychology of situations: An interactional perspective* (pp. 275-295). Hillsdale, NJ: Lawrence Erlbaum.
- Jordahl, H. (2006). *Konkurrensutsättning av offentlig sektor: Hur stor är effektiviseringspotentialen* [Competition in the public sector: How big is the potential for improvements?]. Stockholm: Svenskt Näringsliv [The Confederation of Swedish Enterprise].
- Karambayya, R. (1998). Caught in the crossfire: Women and corporate restructuring. *Canadian Journal of Administrative Science*, 15, 333-338.
- Karasek, R., & Theorell, T. (1990) *Healthy work: Stress, productivity and the reconstruction of working life*. New York: Basic Books.

- Kivimäki, M., Vahtera, J., Pentti, J., & Ferrie, J. E. (2000). Factors underlying the effect of organizational downsizing on health of employees: A longitudinal cohort study. *British Medical Journal*, 320, 971-975.
- Koninck, M., Bergeron, P., & Bourbonnais, R. (1997). Women physicians in Quebec. *Social Science and Medicine*, 44, 1825-1832.
- Kozlowski, S. W. J., Chao, G. T., Smith, E. M., & Hedlund, J. (1993). Organizational downsizing: Strategies, interventions, and research implications. In C. L. Cooper & I. T. Robertson (Eds.), *International Review of Industrial Organizational Psychology* (pp. 263-332). New York: John Wiley & Sons.
- Lachman, M. E., & Weaver, S. L. (1998). The sense of control as a moderator of social class differences in health and well-being. *Journal of Personality and Social Psychology*, 74,(3), 763-773.
- Landelius, A-C. (2006). *Vård och omsorg i offentlig eller privat regi: En rättsvetenskaplig studie* [Healthcare with public or private ownership: Study from a legal perspective]. Stockholm: Jure förlag.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer Publishing Company.
- Lazarus, R. S., & Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of Personality*, 1, 141-169.
- Lewin, K. (1951). *Field theory in social science: Selected theoretical papers*. New York: Harper & Brothers Publishers.
- Liu, C., Spector, P. E., & Shi, L. (2008). Use of both qualitative and quantitative approaches to study job stress in different gender and occupational groups. *Journal of Occupational Health Psychology*, 13(4), 357-370.
- Lundberg, U. (1996). Influence of paid and unpaid work on psychophysiological stress responses of men and women. *Journal of Occupational Health Psychology*, 1(2), 117-130.
- Lundberg, U., & Frankenhaeuser, M. (1999). Stress and workload of men and women in high-ranking positions. *Journal of Occupational Health Psychology*, 4(2), 142-151.
- Lundqvist, L. J. (1991). Privatisering: Varför och varför inte. [Privatization: Why or why not?] In B. Rothstein (Ed.), *Politik som organisation: Förvaltningspolitikens grundproblem* [Politics as ground for organizing: A fundamental problem of governance] (pp. 252-285). Stockholm: SNS.
- Lynch, J. W., & Kaplan, G. A. (1997). Understanding how inequality in the distribution of income affects health. *Journal of Health Psychology*, 2, 297-314.
- Lynch, J. W., Smith, G. D., Kaplan, G. A., & House, J. S. (2000). Income inequality and mortality: Importance to health of individual income, psychosocial environment, or material conditions. *British Medical Journal*, 320, 1200-1204.
- Magnusson, D. (1981). Wanted: A psychology of situations. In D. Magnusson (Ed.), *Toward a psychology of situations: An interactional perspective* (pp. 9-32). Hillsdale, NJ: Lawrence Erlbaum.
- Magnusson, L., & Ottosson, J. (2003). Den tredje industriella revolutionen och "den nya ekonomin": Mellan sken och verklighet. [The third industrial revolution and "the new economy": Between fiction and reality]. In C. von Otter (Ed.), *Ute och inne i svenskt arbetsliv* [Outside and inside in Swedish working life] (pp. 57-76). Stockholm: Arbetslivsinstitutet.
- Marmot, M. (2004). *Status syndrome: How your social standing directly affects your health and life expectancy*. London: Bloomsbury Publishing.
- Marmot, M. G., & Smith, G. D. (1991). Health inequality among British civil servants: The Whatehall II study. *Lancet*, 337, 1387-1393.

- Martin, A. J., Jones, E. S., & Callan, V. J. (2006). Status differences in employee adjustment during organizational change. *Journal of Managerial Psychology*, 21, 145-162.
- Maslach, C., Jackson, S., & Leiter, M. (1996). *Maslach Burnout Inventory* (Research Manual) Palo Alto, CA: Consulting Psychological Press.
- McDonough, P., & Walters, V. (2001). Gender and health: reassessing patterns and explanations. *Social Science and Medicine*, 52, 547-559.
- McLeod, J. D., & Kessler, R. C. (1990). Socioeconomic status differences in vulnerability to undesirable life events. *Journal of Health and Social Behavior*, 31, 162-172.
- Megginson, W. L. (2007). Introduction to the special issue on privatization. *International Review of Financial Analysis*, 16, 301-303.
- Megginson, W. L., & Netter, J. M. (2001). From state to market: A survey of empirical studies on privatization. *Journal of Economic Literature*, 39, 321-389.
- Miles, E. W., Patrick, S. L., & King, W. C., Jr. (1996). Job level as a systemic variable in predicting the relationship between supervisory communication and job satisfaction. *Journal of Occupational and Organizational Psychology*, 69, 277-292.
- Miller, K., & Clark, D. (2008). "Knife before wife": An exploratory study of gender and the UK medical profession. *Journal of Health Organization*, 22(3), 238-253.
- Mohanty, C. T. (2001). Kvinnliga arbetare och kapitalistiska skript: Dominansideologier, gemensamma intressen och solidaritetspolitik [Female workers and capitalistic script: Ideologies of dominance, common interests and the politics of solidarity]. In C. Landström (Ed.), *Postkoloniala texter* [Postcolonial texts] (pp. 131-172). Stockholm: Federativ.
- Moyle, P., & Parkes, K. (1999). The effects of transition stress: A relocation study. *Journal of Organizational Behavior*, 20, 625-646.
- Muhonen, T. (1999). *Kvinnor, karriär och familj – en studie om chefer i fyra olika branscher*. [Women, career and family – a study of leaders in four different trades]. Doctoral thesis, Lund University: Department of Psychology.
- Nelson, A., Cooper, C. L., & Jackson, P. R. (1995). Uncertainty amidst change: The impact of privatization on employee satisfaction and well-being. *Journal of Occupational and Organizational Psychology*, 68, 57-71.
- Newman, J. M., & Krzystofiak, F. J. (1993). Changes in employee attitudes after an acquisition. *Group of Organization Management*, 18(4), 390-410.
- Nunnally, J. (1978). *Psychometric theory*. New York. McGraw-Hill.
- Nystedt, L. (1992). Yrkesofficerares arbetsmiljö i armén: Resultat från delstudie 1 om arbetsmiljö, förtidsavgång och hälsa. [Work environment of army officers: Results of study 1 on work environment, turnover intention, and health. Report C50093-5.3. Stockholm: Försvarets forskningsanstalt [Swedish Defence Research] FOA.
- Öhrming, J. (1997). *Återbesök på centrallasarettet: Vad gick modellerna i hälso- och sjukvården egentligen ut på?* [Another visit to central hospital: What were the different models of healthcare really about?]. Stockholm: Nerenius & Santérus Förlag.
- Öhrming, J. (2008). *Hälso- och sjukvårdens fragmentering: Från lokalt till transnationellt organiserad sjukvård* [The differentiation of healthcare: From local to transnational organization]. Stockholm: SNS Förlag.
- Öhrming, J., & Sverke, M. (2001). *Bolagiseringen av S:t Görans sjukhus: En proaktiv organisering* [Incorporating St. Göran's Hospital: A proactive organizing]. Lund: Studentlitteratur.

- Öhrming, J., & Sverke, M. (2003). Transition towards privatization: Uncertainty and sensemaking in two Swedish emergency hospitals. In J. Hellgren, K. Näswall, M. Sverke, & M. Söderfeldt (Eds.), *New organizational challenges for human service work* (pp. 75-93). Munich: Rainer Hampp Verlag.
- Olson, D. A., & Tetrick, L. E. (1988). Organizational restructuring: The impact on role perceptions, work relationships, and satisfaction. *Group & Organization Studies*, 13, 374-388.
- Östlin, P. (1989). *Occupational career and health: Methodological considerations on the healthy worker effect*. Doctoral thesis, Uppsala University: Department of Social Medicine.
- Orlikowski, W. (1996). Improvising organizational transformation over time: A situated change perspective. *Information System research*, 7(1), 63-92.
- Orpen, C. (1979). The effects of job enrichment on employee satisfaction, motivation, involvement, and performance: A field experiment. *Human Relations*, 32, 189-217.
- von Otter, C. (2003). Inledning: Arbetslivet i kris? [Introduction: Crisis in the working life?] In C. von Otter (Ed.), *Ute och inne i svenskt arbetsliv* [Outside and inside in Swedish working life], (pp. 1-20). Stockholm: Arbetslivsinstitutet.
- Parker, S. K., Chmiel, N., & Wall, T. D. (1997). Work characteristics and employee well-being within a context of strategic downsizing. *Journal of Occupational Health Psychology*, 4, 289-303.
- Paulsen, N., Callan, V. J., Grice, T. A., Rooney, D., Gallois, C., Jones, E., Jimmieson, N. L., & Bordia, P. (2005). Job uncertainty and personal control during downsizing: A comparison of survivors and victims. *Human Relations*, 58, 463-496.
- Perry, J. L., & Rainey, H. G. (1988). The public-private distinction in organization theory: A critique and research strategy. *Academy of Management Review*, 13, 182-201.
- Pratto, F., & Walker, A. (2004). The bases of gendered power. In A. H. Eagle, A. E. Beall, & R. J. Sternberg (Eds.), *The Psychology of Gender* (pp. 242-268). New York: Guilford Press.
- Pugh, M. D., & Wahrman, R. (1983). Neutralizing sexism in mixed-sex groups: Do women have to be better than men? *The American Journal of Sociology*, 88(4), 746-762.
- Quick, J. C., Gowing, M. K., & Kraft, J. D. (1998). Introduction. In M. K. Gowing, J. D. Kraft, & J. C. Quick (Eds.), *The new organizational reality: Downsizing, restructuring and revitalization*, (pp. 15-19). Washington: APA.
- Ramamurti, R. (2000). A multilevel model of privatisation in emerging economies. *Academy of Management Review*, 25, 525-550.
- Ramanujam, R. (2003). The effects of discontinuous change on latent errors in organizations: The moderating role of risk. *Academy of Management Journal*, 46(5), 608-617.
- Ridgeway, C. L. (1991). The social construction of status value: Gender and other nominal characteristics. *Social Forces*, 70(2), 367-386.
- Ridgeway, C. L. (2001). Gender, status and leadership. *Journal of Social Issues*, 57(4), 637-655.
- Ridgeway, C. L., & Bourg, C. (2004). Gender as status: An expectation states theory approach. In A. H. Eagle, A. E. Beall, & R. J. Sternberg (Eds.), *The Psychology of Gender* (pp. 217-241). New York: Guilford Press.
- Ridgeway, C. L., & Correll, S. J. (2004). Motherhood as a status characteristic. *Journal of Social Issues*, 60(4), 683-700.

- Risberg, G. (2004). *"I am solely a professional– neutral and genderless: On gender bias and gender awareness in the medical profession"*. Doctoral thesis, Umeå University: Department of Public Health and Clinical Medicine.
- Riska, E. (2001). Towards gender balance: But will women physicians have an impact on medicine? *Social Science and Medicine*, 52, 179-187.
- Rizzo, J. R., House, R. J., & Lirtzman, S. I. (1970). Role conflict and ambiguity in complex organizations. *Administrative Science Quarterly*, 15, 150-163.
- Robinson, G. E. (2003). Stresses on women physicians: Consequences and coping techniques. *Depression and Anxiety*, 17, 180-189.
- Robinson, S. L. (1996). Trust and breach of the psychological contract. *Administrative Science Quarterly*, 41, 574-599.
- Roethlisberger, F. J., & Dickson, W. J. (1939/1967). *Management and the worker: An account of a research program conducted by the Western Electric Company*. Cambridge: Harvard University Press.
- Rosenberg, G. (1995). Preliminary thoughts on sustaining central social work departments. *Social Work in Health Care*, 20, 111-116.
- Rothman, R. A. (2002). *Inequality and stratification: Race, class, and gender*. Upper Saddle, New Jersey: Pearson Education.
- Sahlin-Andersson, K. (1996). Imitating by editing success: The construction of organizational fields. In B. Czarniawska, & G. Sevón (Eds.), *Translating organizational change*, (pp. 69-92). Berlin: Walter de Gruyter & Co.
- Schaufeli, W. B., Leiter, M. P., & Maslach, C. (2009). Burnout: 35 years of research and practice. *Career Development International*, 14(3), 204-220.
- Serghis, D. (1998). Why hospital privatisation is bad for patients and nurses. *Australian Nursing Journal*, 6(3), 20-24.
- Sevón, G. (1996). Organizational imitation in identity transformation. In B. Czarniawska, & G. Sevón (Eds.), *Translating organizational change*, (pp. 49-67). Berlin: Walter de Gruyter & Co.
- Shaw, J. B., Fields, M. W., Thacker, J. W., & Fisher, C. D. (1993). The availability of personal and external coping resources: Their impact on job stress and employee attitudes during organizational restructuring, *Work & Stress*, 7, 229-246.
- Simpson, L. A., & Grant, L. (1991). Sources and magnitude of job stress among physicians. *Journal of Behavior Medicine*, 14(1), 27-41.
- Sing-Manoux, A., Adler, N. E., & Marmot, M. G. (2003). Subjective social status: Its determinants and its association with measures of ill-health in the Whitehall II study. *Social Science & Medicine*, 56, 1321-1333.
- Sjöberg, A., & Sverke, M. (2000). The interactive effect of job involvement and organizational commitment on job turnover revisited: A note on the mediating role of turnover intention. *Scandinavian Journal of Psychology*, (41), 247-252.
- Smith, G. D., Shipley, M. J., & Rose, G. (1990). Magnitude and causes of socioeconomic differentials in mortality: Further evidence from the Whitehall study. *Journal of Epidemiology and Community Health*, 44, 265-270.
- Södertälje Hospital (1998, 1999, 2000, 2001). *Förvaltningsberättelse & Personalsboksut* [Annual report and personnel account]. Södertälje, Sweden: Södertälje Hospital.
- Söderström, L., & Lundbäck, M. (2001). *Vinsten som drivkraft* [Profit as a driving force]. Stockholm: Svenskt Näringsliv [The Confederation of Swedish Enterprise].
- Spector, P. E. (1994). Using self-report questionnaires in OB research: A comment on the use of a controversial method. *Journal of Organizational Behavior*, 15, 385-392.

- Spector, P. E. (2006). Method variance in organizational research: Truth or urban legend? *Organizational Research Methods*, 9(2), 221-232.
- Spivak, G. C. (2001). Marginalitet i undervisningssmaskineriet [Marginality in the teaching machinery]. In C. Landström (Ed.), *Postkoloniala texter* [Postcolonial texts] (pp. 49-83). Stockholm: Federativ.
- St. Görans' Hospital AB. (1998, 1999.). *Årsredovisning* [Annual report]. Stockholm: St. Görans' Hospital AB.
- Statistics Sweden (2007). Lönespridning efter sektor och kön 2007 [Statistics of salaries divided by sector and gender]. Downloaded 2007-05-25. http://www.scb.se/templates/tableOrChart___149077.asp.
- Steptoe, A., Kunz-Ebrecht, S., Owen, N., Feldman, P. J., Rumley, A., Lowe, G. D. O., & Marmot, M. (2003). Influence of socioeconomic status and job control on plasma fibrinogen responses to acute mental stress. *Psychosomatic Medicine*, 65, 137-144.
- Struwig, F. W., & van Scheers, L. (2004). The effect of privatization on front line employees in a service organisation. *South African Journal of Economic and Management Science*, 7(1) 1-21.
- Swanson, V., & Power, K. (2001). Employees' perceptions of organizational restructuring: The role of social support. *Work & Stress*, 15, 161-178.
- Sverke, M., Hellgren, J., Näswall, K., Chirumbolo, A., De Witte, H., & Goslinga, S. (2004). *Job insecurity and union membership: European unions in the wake of flexible production*. Brussels: P. I. E. - Peter Lang.
- Sverke, M., Hellgren, J., Näswall, K., Göransson, S., & Öhrming, J. (2008). Employee participation in organizational change: Investigating the effects of proactive vs. reactive implementation of downsizing in Swedish hospitals. *German Journal of Human Resource Research*, 22(2), 111-129.
- Sverke, M., Hellgren, J., & Öhrming, J. (1999). Organizational restructuring and health care work: A quasi-experimental study. In P. M. le Blanc, M. C. W. Peeters, A. Büssing, & W. B. Schaufeli (Eds.), *Organizational psychology and health care: European contributions* (pp.15-32). Munich: Rainer Hampp Verlag.
- Sverke, M., & Sjöberg, A. (1994). Dual commitment to company and union in Sweden: An examination of predictors and taxonomic split methods. *Economic and Industrial Democracy*, 15, 531-564.
- Taris, T. W. (2000). *A primer in longitudinal data analysis*. London: Sage.
- Taylor, J. C., & Bowers, D. G. (1972). *Survey of organizations: A machine scored standardized questionnaire instrument*. University of Michigan: Institute for Social Research.
- Tienari, J. (1999). The first wave washed up on shore: Reform, feminization and gender resegregation. *Gender, Work & Organization*, 6(1), 1-19.
- Torkelson, E., & Muhonen, T. (2003). Stress and health among women and men in a Swedish telecom company. *European Journal of Work and Organizational Psychology*, 12(12), 171-186.
- Torkelson, E., Muhonen, T., & Peiró, J. M. (2007). Construction of work stress and coping in a female- and a male dominant department. *Scandinavian Journal of Psychology*, 48, 261-270.
- Tsoukas, H., & Chia, R. (2002). On organizational becoming: Rethinking organizational change. *Organization Science*, 13(5), 567-582.
- Umstot, D. D., Bell, C. H., & Mitchell, T. R. (1976). Effects of job enrichment and task goals on satisfaction and productivity: Implications for job design. *Journal of Applied Psychology*, 61, 379-394.

- Väänänen, A., Pahkin, K., Kalimo R., & Buunk, B. (2004). Maintenance of subjective health during a merger: The role of experienced change and pre-merger social support at work in white- and blue-collar workers. *Social Science & Medicine*, 58, 1903-1915.
- Vahtera, J., & Kivimäki, M. (1997). Effects of organizational downsizing on health of employees. *Lancet*, 350(9085), 1124-1128.
- Wallenberg, J. (2001). *Konkurrens inom sjukvården. Konsekvenser för arbetslivet: En delrapport*. [Competition in healthcare: Consequences for working life: A preliminary report]. IKE-report 2001:112. Stockholm University: The Department of Economy.
- Weick, K. E., & Quinn, R. E. (1999). Organizational change and development. *Annual Review of Psychology*, 50, 361-386.
- van de Ven, A. H., & Poole, M. S. (1995). Explaining development and change in organizations. *The Academy of Management Review*, 20,(3), 510-540.
- West, C. (1993). Reconceptualising gender in physician-patient relationship. *Social Science of Medicine*, 36(1), 57-66.
- Westerlund, H., Theorell, T., & Alfredsson, L. (2004). Organizational instability and cardiovascular risk factors in white-collar employees. *European Journal of Public Health*, 14, 37-42.
- Westlander, G. (2007). *Psychometric concerns in the assessment of intervention effects*. Report No 868. Stockholm University: Department of Psychology.
- Wilkinson, R. G. (1992). National mortality rates: The impact of inequality. *American Journal of Public Health*, 82(8), 1082-1084.
- Wilkinson, R. G. (2005). *The impact of inequality: How to make sick societies healthier*. New York: The New Press.
- Wilkinson, R. G., & Pickett, K. E. (2006). Income inequality and population health: A review and explanation of the evidence. *Social Science and Medicine*, 62, 1768-1784.
- Zapf, D., Dormann, C., & Frese, M. (1996). Longitudinal studies in organizational stress research: A review of the literature with reference to methodological issues. *Journal of Occupational Health Psychology*, 1, 145-169.