Motivational paradigms for the integration of a Belgian hospital network and merger presented in the printed press.

Introduction

Governments stimulate collaboration in healthcare services to rationalize or improve healthcare (Gaynor et al., 2012). At the same time, the evolution towards patient-centered care asks for integration of care across hospital boundaries (Beech et al., 2013). New organizational forms, e.g. networks, strategic alliances, or multihospital systems, that allow more intense collaboration among healthcare disciplines and providers have emerged to cope with these new policy requirement (Burns and Pauly, 2002). Integrated delivery networks often fail in meeting the expectations of government and other stakeholders (Rummery, 2009). Burns and Pauly (2002, 2012) criticize all forms of integration, from networks of hospitals to horizontally or vertically integrated care providers and accountable care organizations. Others warn that the advantages of networks are overrated, that the disadvantages are not enough known, and that they might outweigh the advantages (Currie et al., 2008, Rummery, 2009). Some of the known reasons for failure are related to the expectations and motivations for establishing the new organizational form (Burns and Pauly, 2002, Burns and Pauly, 2012, Rummery, 2009). Gaynor et al. (2012) explain that in the UK, hospital mergers are justified with economic and care quality arguments but that the mergers did not meet the expectations that were created. Weil (2010) confirms that the reasons used for legitimizing hospital mergers do not comply with the objectives reached through the mergers. A better understanding of the perceived rationales behind co-operation, integration and mergers, how these evolve over time, and especially, how the

legitimation of the integration is communicated to the public, are a prerequisite for more effective collaborations and support from stakeholders for the integration or merger. Integration among care organizations is a complex issue (Goodwin, 2013), and it is not the purpose to develop an exhaustive analysis of the legitimation of an hospital integration process; but to learn how this process is legitimized in the press over the integration period.

This study is situated in the Belgian healthcare setting, which is highly characterized –similar to other continental European countries- by the influence that government has on the healthcare regulation process through the financing structure (Antunes and Moreira, 2011, Arnaert et al., 2005, Gaynor et al., 2012). The Belgian healthcare system (Gerkens and Merkus, 2010) is financed by the state through stated-funded or subsidized care institutes and through reimbursement of care based on an obligatory healthcare insurance system. It consists of public and non-profit hospitals and healthcare organizations, and patients are free to choose among the healthcare organizations. In Belgium, governments are thus heavily influencing the structure of the hospitals, either directly by owning and controlling public hospitals or indirectly by regulating all hospitals, e.g. by imposing a minimum number of patients and beds. Since the government supports and even enforces the formation of intense collaboration in the form of networks, alliances or even mergers, it is interesting to examine with which paradigms such collaboration is justified in the communication towards the general public.

To explore how a large hospital integration process was justified or explained to the public, communication in the printed press related to the integration of one large hospital network was studied using the van Raak, Paulus and Mur-Veeman (2005) framework of motivational

paradigms. Analysis of general newspaper articles is suitable to learn about the expectations created among the general public (Thomson, 2008). The general printed press provided justifications for the integration, which influences the public opinion. Often the printed media forms a critical assessment of the events that take place and the decisions that are made or confirms existing opinions of the public. These justifications in the printed press are an indication of the legitimacy of the new organizational form (Vergne, 2011). It is not our intention to compare the real rationales of the different stakeholders, but rather to explore the motivational paradigms used for the legitimacy of the new organizational form that appeared in the media over time. In an institutional context, where integrated care through different organizational forms is promoted but of which for each form the success rate is questioned, insight into how such integrations are -despite the critics- justified, how this justification evolves over time and during the process towards centralization, and whether a particular paradigm dominates in the motivations spread through the printed press, are necessary. Such legitimization might then in turn influence several other stakeholders, e.g. staff and patients, who -in their reaction on the dominant motivational paradigm reflected in the media- take part in the success or failure of the healthcare-networks.

Theory and Conceptual Framework

Provan et al. (2011) indicate networks of healthcare organizations as several organizations with a collective goal and collective actions required to provide effective care. However, hospitals also co-operate for other reasons, often economic ones. In several European countries restructuring of the healthcare sector took place resulting in the formation of alliances and mergers for several reasons of which integrated care was often not the main

reason (Weil, 2010). Chu and Chiang (2013), for instance, found that strategic alliances among hospitals in Taiwan improved in hospital performance, in care quality and in operational efficiency. Initial collaboration between hospitals can develop in strategic alliances and in a last stage in an acquisition or merger. Lowensberg (2010) referred to the problematic nature of the concept of 'strategic' and 'strategic alliances' in particular to the ability to clearly define the concept. They conclude with the definition: "a strategic alliance is the planned working together of various organizational partners to achieve one or more goals (Lowensberg, 2010:1093)". The case in our study evolved from collaboration in a network form, over strategic alliance, into a merger.

Legitimating alliances and mergers in healthcare

Effects of mergers in the healthcare sector have been subject to several studies (e.g. Acevedo and Common, 2006; Johar and Savage, 2014; Lim, 2014). These studies have been looking at the effects on employees of the hospitals, quality of patient care, or cost efficiency. The results are very mixed and certainly not dominantly positive. Mergers can cause inefficiencies and potential cost savings are not guaranteed, even not over a longer period (Gaynor et al., 2012, Harrison, 2011). However, how the merger and expectations are managed are important to obtain positive merger effects, e.g. on job satisfaction of staff (Lim, 2014). Organizational structures to integrate care organizations, such as alliances or mergers, are often not initiated to improve care but for economic reasons; and it cannot be expected that better integrated care results automatically from organizational integration, on the contrary (Gaynor et al., 2012, Demers, 2013). But even those economics of scale effects are hard to achieve. Azevedo and Mateus (2014) found negative economics of scale among the larger merging operations in Portugal. A Danish study is more hopeful with

positive economics of scope and scale effects after a restructuring of the Danish hospital sector, including merging hospitals (Kristensen et al., 2012).

However, whether reasons are economical or health care related, the integration needs to be legitimate in the perception of the stakeholders. In doing this, hospital management or governments mandating the mergers use several arguments and create expectations. UK Government for instance actively simulated hospital mergers arguing that care would improve, but this effect could not be proved and the mergers did not result in improving the poorly performing hospitals (Gaynor et al., 2012). Mergers create uncertainty among staff and other stakeholders. Managing this uncertainty is one of the success factors of hospital mergers (Thier et al., 2014). Intended or unintended communicating around the merger influences the expectations and uncertainties. Especially given the fact that evidence on the benefits of integrating and merging hospitals are not overwhelming, the way the merger is legitimated is important for the perception of stakeholders. Weak evidence on the benefits of the integration process leaves room for influencing the perceptions of stakeholders and for multiple interpretations of the rationales for the integration. Comtois et al. (2004) have shown how mergers were legitimated using several arguments, while the mergers were mainly political strategies. Numerous studies by Vaara and colleagues (Hellgren et al., 2002, Vaara and Monin, 2010, Vaara and Tienari, 2002, Vaara and Tienari, 2011, Vaara et al., 2006) were done on the legitimation process of mergers and acquisitions. They emphasize the role of the media in the legitimation process. Strategic integration actions of restructurings are legitimized and this legitimation in turn can be the basis for future actions, the identity of the new organizational form, perceptions of success and failure, and power and positions of key actors in the integration process (Vaara and Monin, 2010). Although the legitimation process is based on perceptions and representations to stakeholders, it can influence

through the legitimation process also the actual success or failure of a merger. In the UK healthcare context, Thomson et al. (2008) also emphasize the role of media in legitimizing health sector reforms. They found that the media portrayal of the changes in the sector was rather negatively influencing the change process. In our study, the perceptions expressed in the printed press of the motivations for the integration and merging process, influencing the public opinion, were studied.

Motivational paradigms

To reveal the motivational paradigms used to legitimize the integration and merging process, an aggregated organizational perspective based on the framework of Barringer (2000), including six paradigms, is used. This is consistent with literature on motivations for inter-organizational relationships in general business setting and in a healthcare setting, such as van Raak et al. (van Raak et al., 2005), and Lowensberg (2010). These paradigms are: Transaction cost economics, Strategic choice theory, Resource dependence theory, Organizational learning theory, Stakeholder theory and Institutional theory. Each of the paradigms is based on a long history of research and theory development and together these paradigms form an exhaustive set of motivational paradigms. Taking a holistic view bringing such broad fields of research together involves unavoidable a simplification of the paradigms. Nonetheless, this approach turned out to be very useful in previous research to explain the formation of strategic alliances (Lowensberg, 2010) and to explain co-operation among healthcare providers (van Raak et al., 2005). A comprehensive overview of the six widely used theoretical paradigms can be found in the review by Barringer and Harrison (2000).

Transaction cost economics focuses on minimizing production and transaction costs through inter-organizational relationships. Motivations to ‘make’, ‘buy’ or ‘partner’ are based on cost reduction. An alliance is judged on whether it is most advantages to develop the service yourself or whether it is better to 'buy' it from another organization specialized in this service. Arguments in favor of buying are: the specialized organization is able to develop and deliver the service cheaper considering transaction costs. These costs are related to developing and enforcing the contracts, and costs related to opportunistic behavior of the selling organization. In an alliance or network relationship in which a more long term and more trust-based relationship is developed, costs related to contracts and opportunistic behavior are lower, favoring the 'buy' or in fact 'alliance' option to obtain the services. Yu and Chen (2013) studied hospital-based health networks in Taiwan from a transaction cost theory lens and found based on this perspective that the networks were resulting in higher performance. Weil (2010) found no positive transactions costs effects among hospital mergers. According to Lowensberg (2010), this motivational paradigm might not be of great importance as a real motivational factor for alliance formation. Nonetheless, the argument that alliances will reduce transaction costs might still be used to legitimize alliances and even mergers (Weil, 2010).

Resource dependence theory explains the motivation for inter-organizational relationships by the need for scarce resources. In an integrated healthcare context, this could be a very useful paradigm because each organization in the network might possess different medical expertise or possess unique medical equipment (van Raak et al., 2005). From a resource dependency perspective, control over the resources -and not only ownership- is important. Organizations need resources that are scarce and also crucial but not owned by the organization. Through alliances, the organization can obtain control over these important

resources. Such resources can be financial, knowledge and expertise related, specific assets, human resources, or any other scarce resource. The more an organization has control over resources, the more powerful and competitive the organization is and the better it can survive. All organizations need resources form other organizations but through alliances, those resources are not achieved in a market setting but exchanged in an alliance relationships allowing much more control over the resources than in a market setting. Hence, not costs but control is here of key importance. In a German study, inter-organizational relationships were positively associated with financial performance from a resource-dependency perspective (Gloede et al., 2013). Resource-dependency in a healthcare context seems to be a very suitable argument to justify alliances because of the complexity of healthcare preventing single organizations from having all medical expertise.

In the *organizational learning theory*, absorbing knowledge and learning from partners is key to the organization's success. Learning organizations absorb knowledge from their environment and adapt based on this knowledge. The level of absorptive capacity is crucial in the success of learning and knowledge exchange in the network (Cohen and Levinthal, 1990). Through alliances and networks, hospitals can learn from each other and exchange technical and medical knowledge, which then can result in increased performance. Having superior knowledge can lead to a competitive advantage. Although the potential performance effects are not easily predictable in advance because these depend on the learning ability and trust among the organizations in the alliances (Liu et al, 2010), the organizational learning paradigm might still be a strong paradigm to justify alliances to the public.

Stakeholder theory refers to the responsibilities towards stakeholders in making decisions on inter-organizational relationships (Baker et al., 1999; Page, 2002). Organizations operate in

open systems with mutual influencing between the organization and its stakeholders. Main stakeholders of hospitals are the government, patients, physicians, competing hospitals, and health insurance organizations. Given the high impact of stakeholders in the health sector in Belgium, such as local governments and other care organizations, the stakeholder paradigm might be very useful in legitimizing alliances. Through collaboration with stakeholders, uncertainty is reduced, synergies are created, or goals of the organization and its stakeholders are more aligned. Carruthers, Ashill, and Rod (2006) for instance give the example of collaboration between stakeholders in a purchaser-provider relationship resulting in a shift from a market relationship towards a cooperation relationship and a better alignment of the goals of both partners. Mur-Veeman and Govers (2011) show in a Dutch study how lack of collaboration between stakeholders in the chain of care (the patient flow from hospital to nursing home) prevented successful patient flows, due to different but persistent routines, principles and beliefs among the stakeholders.

Institutional theory explains the development of inter-organizational relationships and networks as caused by isomorphic pressure and efforts to obtain legitimacy. Networks in healthcare can be formed because it is believed to be the way to deliver integrated care, even without evidence of success (Burns and Pauly, 2002), or as a result of a process of historical institutionalism (van Raak and Paulus, 2008). Alliances can occur because it is the expectation or norm, or a requirement one needs to comply with. By complying with the norms and expectations, organizations obtain legitimacy, also called institutional legitimacy (Garcia-Pont and Nohria, 2002). Alliances can also provide legitimacy because the partner is highly respected. Institutional theory refers also to the habit of copying behavior of other similar organizations from the perspective that success might be copied or that if not copying the behavior of others your organization might get 'behind'. However, starting an

alliances because alliances among competitors are deemed successful (competitive isomorphism) is not a strong argument because of causal ambiguity about the reasons for success (Garcia-Pont and Nohria, 2002). Nevertheless, institutional pressure and even fashion heavily influence strategic decisions such as alliances, networks or even mergers. Comtois et al. (2004) studied hospital mergers in Canada and concluded that institutional pressure is an important argument used to legitimize hospital mergers, next to political arguments and efficiency arguments. The healthcare sector, which is heavily institutionalized, and in which legitimacy is important, might be very sensitive to the institutional theory paradigm (Grafton et al., 2011).

Finally, s*trategic choice theory* approaches inter-organizational relationships from a competitiveness perspective; e.g. hospitals might be able to provide higher quality integrated care or allow growth through the relationships (van Raak et al., 2005). A critic to this theory is that it is that broad involving any objective by management to engage in a network. In fact choosing an alliance to lower transaction costs or to increase quality of services based on getting control over unique expertise are also strategic choices. This theory thus serves more as a generic paradigm in management that can easily be found in combination with other paradigms. Nonetheless, one might argue that competitive strategies (e.g. gaining market power) or strategic business opportunities lay at the basis of the alliances or mergers and that the alliance needs to fit in to the strategic goal setting of the management of the organization. This might sound logic but is very often not the case. Many collaborations in the healthcare sector are mandated by governments (van Raaij, 2006, Grafton et al., 2011). The mandated character of collaborations might influence the intensity of collaboration, the effectiveness, and collaborative structure. Nonetheless, strategic choice paradigm might be less suited to legitimize alliances because of its

vagueness and broadness. Specifically, in the European healthcare context, and certainly in the Belgian context, where governments and other stakeholders heavily influence strategic choices, the strategic choice paradigm might not be very useful. Weil (2010), however, indicates that strategic choices, such as increasing market share and increase market power, might be the real reasons behind hospital mergers in Europe and North America.

Barringer and Harrison (2000:367) already stated in their review that ``*blending the theoretical paradigms together may provide an even more useful means of understanding the formation of inter-organizational relationships*.'' The idea that all paradigms need to be combined to explain strategic alliances was further explored by Lowensberg (2010). Lowensberg (2010) links the six models not only with each other but also with a management process. He argues that the Strategic Choice is the overall motivational element and can be viewed as being embedded in the other paradigms. The Strategic Choice is also the link between the management process and the five other paradigms. This holistic view by Lowensberg (2010) is represented by the use of overlapping circles, in contrast with the representation from Barringer and Harrison (2000) which places the paradigms on a scale from an economic inspired rationale towards a more behavioral rationale. The Strategic Choice Theory is represented by the circle that surrounds all other circles and thus forms the basic platform for all other theories. At the same time, this theory is included in a feedback-loop which depicts the continuing management process, since strategy is determined by management.

The six theoretical paradigms each try to explain the motivation behind the formation of inter-organizational relationships. They provide together a very wide view on this matter and provide possible answers to the `why' question of healthcare networks and alliances. When

applying them, a holistic view is advised. They are not only useful during the formation of networks but can also be considered during the entire life-cycle of inter-organizational relationships. An example of the first application of the model to explain why care providers co-operate is provided by van Raak, Paulus and Mur-Veeman (2005). Although the model, which is an organizational theory model, is intended to explain perceived motivations of integration and inter-organizational relationships, it can also be used to study which motivational paradigms are used to legitimize integration. The view of Lowensberg (2010) was followed here, with the Strategic Choice theory as basic platform. The Strategic Choice theory was, thus, not taken into consideration, since, as stated by Barringer and Harrison (2000:375) "nearly all of the other perspectives in this section can be incorporated into strategic choice. While breadth is an important strength of the strategic choice perspective, it may also be its greatest weakness."

In our study one case in Belgium is studied, which allowed to comprise data covering a period of a decade. The source of our data, communication in the printed press, allows to focus on the legitimization of the integration process. Instead of investigating how today, the merger is legitimized, we give an image of what the motivational paradigms used where at that time in history -according to the opinions in the media- and how they may have changed through time. Insight in such evolution can reveal whether the same paradigms are used throughout the integration process or whether there is an evolution in the paradigms mirroring the integration process.

Methods

A single case study method is applied in the Flemish care setting, and more specifically on the formation of Antwerp Hospital Network (in Dutch: Ziekenhuisnetwerk Antwerpen; abbreviated as: ZNA). Starting from several loosely coupled care organizations facing financial losses, these organizations integrated within a decade into the ZNA network and finally merged into the largest integrated (health)care provider in Belgium in terms of consultations, and became viable again. Although the city of Antwerp had controlling authority over the current and past care organizations involved in the network and merger, the care organizations could be considered as largely independent organizations. After the merger ZNA consisted of eight day centers, three general hospitals and six specialized hospitals. In Belgian, ZNA is the largest care provider and also within Europe it is among the largest care providers. This merger is, thus, an example of a large scale up in healthcare. Given the scale and the historically independency and competition between the care organizations, motivating and legitimizing the integration process to the public were important.

The key events in the process were: a) the revealing of the huge losses in 2001, b) signing in 2003 an agreement between the city of Antwerp and the hospitals about a settlement for the debts and a plan to make the hospitals financially healthy, c) starting in January 2004 under guidance of a new CEO for ZNA the process of integrating the hospitals into one organization (ZNA), d) the integration process officially ended in June 2007 with one legal entity, and e) in June 2008 ZNA announced that it made a profit. The case was studied from 2001 until 2011 allowing for the very first start of the process until a couple of years after the merger was legally a fact.

The ZNA is the case and unit of analysis. In a case study research design, qualitative or quantitative data collection strategies can be used (Yin, 1994). Here, quantitative and qualitative research strategies based on secondary data were combined to obtain triangulation and to improve the validity of our findings. The first analysis was started from the data and identified semi-automatically the important topics and trends, based on observed frequencies, and could be considered a more quantitative approach. In the second analysis part of the data were reexamined and coded manually, allowing a more qualitative approach. Both methods generate aggregated data about the dominant motivational paradigms used by the press to legitimize the network. Finally, the press articles were studied qualitatively to build the story of ZNA as brought to the public by the general printed press. Working with secondary data to reproduce past events has the advantage of not being biased by the selective memory of respondents. Hence, it is suitable to picture an evolution over a period of ten years. Using secondary data has several limitations as well. First, it is not telling the true reasons of the decision-makers in the integration process of ZNA or why certain paradigms dominated in a certain period of time. Nor does it provide insight into the development process of the integration or the different (conflicting) views of the stakeholders. The case of ZNA is interesting and can be studied from many perspectives and through many research strategies all able to reveal some aspect of the integration process. Here our study only focused on one aspect, namely obtaining insight into the evolution of motivational paradigms used to justify the merger to the broad public in the press. Using press articles to study legitimization of alliances and mergers is not unique but used in previous research such as Riad et al. (2012), Vaara and Monin (2010), Vaara et al. (2006), Vaara and Tienari (2002), Hellgren et al. (2002), Kuronen et al. (2005), and in a healthcare context by Thomson et al. (2008). Press articles as secondary data are not objective and

might be colored or interpreted by the journalists. The motivational arguments might not be the true arguments but these are the arguments presented to the public and influencing the public opinion. This public opinion is important in a highly visible and government funded sector.

A text analysis was performed on all relevant Flemish articles accessible through the Mediargus archive. Mediargus offers the archive of all Flemish newspapers and the publications of the Roularta Media Group, including several weekly magazines. Magazines that represent a particular stakeholder, e.g. a nursing magazine, were not included. Only those Flemish publications that appeared during the whole timeframe of the study and had a relevant scope were selected, in particular seven daily newspapers and two weekly magazines were selected. The timeframe of the study is 1 January, 2001 until 30 June, 2011. A total of 1527 articles were used to perform the analysis. The articles written by journalists express the opinion of the media, one of the network's stakeholders, based on the interpretation of the actions taken by the network over time and the information and signals this network sends out. Hence, the selected articles do not represent opinions or motivations of the management or board of the network, nor of a particular stakeholder, such as the government or doctors.

Quantitative research strategy

First, the 1527 extracted articles were entered in Nvivo9 and coded electronically to build a coding map starting from the data. The decision to use Nvivo9 was founded on the decision tree developed by Auld et al. (2007). The method described below ensured a wide open perspective on the case without preconceptions and ensured a high repeatability and

reproducibility. The 2000 most frequent stemmed words of at least four letters were automatically selected using NVivo.

Second, this list of 2000 words was manually screened and only those who could be of any value for further analysis were preserved. The preserved words were classified in meaningful groups according to their subject, keeping in mind what kind of subjects may or may not have a value for an analysis within the scope of this research. Examples of such groups are "money and finance", “stakeholders”, and "quality and safety". Words that could imply several meanings depending on the context were avoided as much as possible. The newspaper articles were also coded on which semester between 2001 and 2011 these were published and in which publication this was. This allowed mapping the appearance of the codes over time. Hence, by grouping the most frequent used words, certain themes arose and were mapped over time. When the numerical values of the frequencies of text fragments coded on a certain code were analyzed relative to the total number of relevant published articles, the appearance of certain trends arises. For example, there were 18 text-fragments coded on ‘quality and safety’ in the second semester of 2004. In this second semester, a total number of 84 articles were identified from the Mediargus database about ZNA. This means that the theme ‘quality and safety’ appeared 18 times over 84 articles, or as a percentage 21 percent. Note that it is possible to reach a percentage over 100% when there are more text fragments with a particular code then articles in the period. Hence, the exact value of the indicator for the frequency of a specific code is less important compared to the relative size of the indicator in comparison with the indicators of the other codes; e.g., indicators for ‘money and finance’ versus ‘operational focus’.

This method depends largely on automation, with little room for interpretation, and resulting in objective, and quantifiable results. A drawback is that it quantifies the use of words, but words are used in a context and can have different meanings in different contexts. Especially whether the words are used in a positive or in a negative context is not accounted for. The method has, however, the advantage of scale, and it can be expected that the errors will be small relatively to the data-set and therefore, the observed trends are a representation of true trends.

Qualitative research strategy: coding text fragments

In the second step, a more qualitative research strategy applied a manual coding of a part of the same data, starting from the five theoretical perspectives. This coding was of a smaller scale and more subjective, but gave more insight in the contexts and applied arguments. Data were re-examined and manually scanned for arguments that were given in the printed press on why the network was formed. These arguments were coded corresponding the theoretical paradigms these can be accommodated to. A qualitative analysis demands a smaller sample. To take a subsample, a quick visual scan of the article, the headlines and the main topics was done. Articles having a core focus on e.g. accidents, without a focus on organizational matters but mentioning the collaboration or integration process towards the merger, were excluded. From the original 1527 articles, based on scanning the headlines and intro of the articles, 156 articles could be selected that had a core focus on the organizational aspect of the development of the ZNA. These articles were closely examined and coded. Most of these articles contained several text fragment. Hence the 156 articles contained 321 text fragments. It were these text fragments that were coded in this second phase of the data analysis. This manual coding differs from the automatic coding in several

ways. First, the coding is based on a whole text fragment and the context of the text-fragment – the rest of the article- is taken into account. Second, in order to allow such coding, a rather narrow interpretation of the paradigms was required. In particular, the descriptions of the paradigms from Barringer and Harrison (2000) were used and for each paradigm the baseline argument was used as criteria to decide whether a text-fragment was labeled with one of the paradigms. For instance, in the transaction cost theory, the baseline is cost-minimizing and, hence, text-fragments explicitly referring to cost-minimizing were labeled as transaction cost theory. In a most broad interpretation of the paradigms, most arguments could have been labeled as related to each of the six paradigms. Not surprisingly, since most theories have been developed with the ambition to explain the whole rationale of inter-organizational relationships. This enhances their generalizability. At the same time, the use of a broad interpretation would limit the internal validity of the results. Which of both interpretations, broad or narrow, is most valuable, is open for discussion, but, to obtain internal valid results, a narrow interpretation was preferred. Nonetheless, several text-fragments could not be attributed to a single paradigm and were, therefore, attributed to more paradigms. Third, one author coded all articles allowing consistency in the coding but another author did a double check on some of the coding to see whether the coding was consistently applying the baseline arguments of the paradigms. There was no independent double coding applied which is a limitation to our study but, unlike coding of interviews, coding of newspaper articles is much more straightforward.

An example of a coded text fragment is given here, for each of the five paradigms:

- Institutional theory: “The longterm cut-back of 600 jobpositions is part of the ZINA-plan, which should make the virtually bankrupt hospitals viable again. That was the

requirement of the municipality in the Valentines-agreement, in which the city agreed to take over the debts of the hospitals." (De Tijd, 19-09-2003, p32)

In this text phrase, the baseline argument is compliance with the requirements of the stakeholders, which falls within the institutional theory paradigm.

- Transaction cost economics: "All hospitals will be reprofiled: they will specialize in a branch, for example psychiatrics, geriatrics, revalidation or acute interventions. By centralizing specialities, we will be able to cut a lot of costs." (De Morgen, 19-09-2003, p.5)

The baseline argument is cutting cost.

- Resource dependence: "ZNA will raise efforts in the struggle against cancer. The hospitals will attract three oncologists and a hematologist. This team will shuttle between the cancer-departments of the different hospitals" (De Morgen, 25-07-2005)

Here the relationships between the hospitals are viewed in terms of depending on each other's unique resources.

- Organizational learning: "Cooperation means an improvement of quality. How do you think a doctor will ameliorate? If he sees patients with the same disease five times a year, or if he sees them every day? By referring the patients to the specialized doctors, they too will expand their know-how. The hospitals assert that the cooperation will prepare better physician-specialists." (De Standaard, 11-07-2006, p.42)

Here cooperation is reflected in higher quality through organizational learning and clearly fitting in the organizational learning paradigm.

- Stakeholder theory: " In case of heavy accidents and trauma's, it is better for the patients if they arrive in a big emergency department, where specialised doctors provide care 24/7. That's not feasible in smaller emergency departments like the one of Sint-Erasmus." (Gazet van Antwerpen, 19-11-2010, p.54)

This text phrase is mainly about better services towards the customers (stakeholders) and thus responsibility towards stakeholders, which is reflecting the stakeholder theory paradigm.

Qualitative research strategy: constructing the story

Based on the 156 articles, the 'story' that is being told by the newspapers to the general public can be reconstructed. In this phase, the facts and events in the articles about the process of integration into a network and later a merger were derived from the articles. This was not based on automatically or manual coding of text fragments but through reading the articles in order of publication date and reconstructing the process or 'story'. In this stage the articles were used as they were intended, namely bringing a message across. Hence, not the number of articles on a certain event matter but only the fact that the event was mentioned, allowing us to describe the process.

Results

Quantitative research strategy

Based on the quantitative method, when looking at the evolution of the appearance of the different codes over time, certain trends emerge from the collected data. Representations of the most clear trends in the codes are given in graphs 1 to 4. The groups of codes indicating clear trends are: stakeholders (graph 1), financial issues (graph 2), quality and specialization

(graph 3), and medical terms and patients (graph 4). Each of these graphs displays the trends for several codes in the group. For instance: 'government and politics', 'health insurance organizations', 'management', 'OCMW', 'and 'unions' for the group of codes for stakeholders. The trend lines indicate the relative frequency of appearance the codes.

Insert graphs 1 to 4

Some of the trends are easy to explain and as such, can be used to verify the results. For example in graph 1, a distinct decrease in the use of the term 'OCMW' is visible from 2005. Which is obvious since the 'OCMW'-hospitals (OCMW indicates public health hospitals and are distinct from private hospitals) changed their name in the beginning of 2004 and started to use the group name for the co-operating hospitals, namely ZNA.

Graph 1 shows further large frequencies on codifications concerning government and politics in the beginning of the study-scope indicating that these were frequently mentioned in the press concerning the merger but remained important during the whole process. The management of the hospitals were more mentioned as the integration developed. Unions, representing different groups of staff, were mentioned more at specific periods in the process. Health insurance is an important stakeholder but not frequently mentioned in the press in relation to this hospital restructuring operation in Antwerp.

Graph 2 shows that in the time-span between 2002 and 2004, money and financial related words are more frequent then in the rest of the study-scope. Especially the focus first on cutbacks and then on debts in the period before 2005 is clear. However, cutbacks remain

gaining attention throughout the period; while the debt issue was solved and not mentioned anymore.

While in graph 1 and 2, the words related to stakeholders and financial issues decreased, words related to quality and specialization increased. In the time-span between 2005 and 2009, the results in graph 3 show an increased attention for research and education, specialization and quality and safety. Especially in the period 2002-2005, 'debts' dominated the press articles on ZNA, while words related to quality were rare.

In the years following 2005, the results in graph 4 show an increased attention for the patients, the public and medical related items. This increase is more distinct in 2009. Interesting is the rather low appearance of the codes 'patients and public' in the turbulent first years of the integration process.

Combining the graphs reveals that articles on ZNA were dominated by words such as 'government and politics' and 'debts' in the first years when ZNA was formed; while in the later years more words as 'research' and 'medical' appeared. Hence, in the articles on the ZNA integration and merging process, an evolution can be observed from stakeholders and debts towards more healthcare related words.

Qualitative research strategies

Based on the qualitative method, when looking at the appearance of the different motivations and matching them with the theoretical paradigms, arguments can be found for the case of ZNA for each of the five theoretical paradigms. This qualitative analysis is again represented in a time line allowing comparison with the quantitative analysis. When coding all fragments according to the paradigms and putting these against the time line by counting for each semester how many text phrases were labeled according to each of the paradigms,

again a trend line but now based on qualitative coding of text fragments appears. An overview of all the codifications in terms of relative frequencies is given in graph 5. The dots indicate the number of references for a certain paradigm relative to the number of published articles. Each dot on the trend lines, thus, gives an indication of the relative frequency the paradigm appeared in the articles. The five trend lines together indicate which paradigm was mentioned most compared to the other paradigms. Graph 5 shows that all five paradigms contain value in explaining the rationale of the inter-organizational relationships between the hospitals of ZNA because they are all to some extend present over the period of ten years, although in some semesters a paradigms did not appear (for instance institutional theory in the first and second semester of 2010). The chart indicates that not all paradigms were present equally strong over time. There is a distinct evolution over time observable, and more precisely, the five paradigms take the highest values one after the other. In particular, institutional theory and transaction cost theory are most dominant in the coded articles in the first three years of formation of ZNA. From 2005 until 2007, organizational learning became more prominent, but also transaction cost theory and resource dependency were present. In the last years, stakeholder theory was most prominent and dominated over the other paradigms, while it was almost absent in the first years. From 2006 on, institutional theory disappeared almost. From 2007 onwards, transaction cost theory became less prominent in the articles. These are the two paradigms that were dominant in the first years. Organizational learning was present during the whole period of ten years but with a dominant period in the middle part of the graph. The trend lines for the institutional and stakeholder paradigms are very clear. This is less the case for resource dependency. Over the whole period resource dependency was strongly varying in absolute count and relatively compared to the other paradigms.

Insert graph 5

The 156 articles do not only indicate different paradigms but also illustrate the process of integration and development of the ZNA. Or in other words, they tell the story of ZNA. The story of ZNA started with a change in the environment; i.e., the government imposed a new attitude on the hospitals. This matched Institutional Theory. *"The chair of the Antwerp OCMW asked for an urgent parliamentary debate on the role of public hospitals in large cities. Those hospitals are legally obliged to provide urgent medical care to each person living in Belgium (De Morgen, 14-10-2002, p4)."* A major focus was put on the financial viability of the hospitals. The government took on the debts and in return demanded no more debts in future. Reducing costs was put forward as the driving factor of the formation of the network. *"At the end of 2002, the debts became so huge that the OCMW hospitals were virtually bankrupt; said the chair of the OCMW. And because we want to guarantee healthcare for each one and avoid a social disaster, I went begging. I did not get much response from the federal and Flemish government. The city council was willing to help on the condition that we would not make new debts and that we would transfer the OCMW hospitals to a nonprofit legal entity (De Standaard, 23-07-2003, p 10)".* The hospital were put in one network and urged to cooperate but it was clearly not a voluntarily collaboration. In the Zina-plan the restructuring of the hospitals, including a serious reduction of employees and cost cutting, was outlined. Transaction Costs Economics succeeded and paralleled Institutional Theory. Overlapping services were eliminated as much as possible, personnel was relocated and had to deliver more flexibility. Payments by the patients received more attention. *"The Antwerp*

OCMW hospitals are from the first of January 2004 under one roof: Zina, which stands for Hospital Network Antwerp. This new nonprofit organization must lead to a cheaper and better collaboration among the institutes (Het Laatste Nieuws, 23-07-2003, p 17)". These actions often were received with resistance, strikes, negotiations etc. Now that there was a network, there was control and power over the scarce resources within the network. Negotiations were started with the government and health insurance organizations to obtain more financial means. Recruitment events were held to obtain scarce qualified personnel. This matched the use of the Resource Dependency theory to legitimate the process. The control over the scarce resources had led to reorganizations*. "The collaboration starts to lead to success stories. Het UZA [university hospital Antwerp] didn't have a radiation therapy department, but will get one through the alliance with ZNA. This had already a well-developed radiation therapy department for many years and through the alliance it now receives the label 'university'. Moreover, UZA has now sufficient training and internship places available for its students (De Standaard, 24-11-2006, p 82)".* The scale of the network had allowed to assign more specialization in the separate parts of the network. It also allowed to invest in expensive equipment, in research and in innovation. These occurrences allowed to use Organizational Learning as paradigm. There was more specialization possible due to the larger scale but also more room to experiment with new processes and care. *"In the Antwerp hospital ZNA Jan Palfijn medication will be allocated fully automatically. This is new for Belgium.[...] ZNA will implement this system in all its hospitals. (De Morgen, 21-04-2007, p9)"* Eventually, the integration process could be further legitimized by indicating that this organizational learning resulted in higher quality care and benefited the patients. This matched Stakeholder theory in which collaboration is explained in terms of benefits for the stakeholders, which are here among other patients, governments, and politicians

representing citizens using -and through taxes- paying for the health care system. More and more changes and new initiatives in the hospitals were no longer legitimized in terms of requirements, financial terms or resources but also in terms of care for the patients and other stakeholders. E.g. *"For the ZNA-location Stuivenberg en Erasmus will we reconsider the tasks. A number of tasks will be regrouped. This is easier for our patients (Gazet van Antwerpen, 18-05-2011, p 13)"*.

Discussion

When combining the coding based on the frequencies of words, the manual coding based on the paradigms, and the qualitative interpretations to build the story of ZNA, some resemblances and relations emerge. For example, in the first stage of the integration process, the external pressures mentioned in institutional theory can be associated with "Government and politics" as illustrated in graph 1. Transaction cost economics can be associated with financial related codes as show in graph 2. Resources Dependency theory can include pressure on the available resources, which is often associated with the intervention of Unions for which the frequencies are shown in graph 1. Organizational Learning can be associated with "Research and education", "Quality and safety" and "Specialization" as shown in graph 3. And considering the patient as the ultimate stakeholder when providing integrated healthcare, the data in graph 4 can be associated with Stakeholder Theory. When combining the results of the three methods and considering the associations, there is a clear similarity between the time-spans in which the associated terms and the five paradigms have elevated values. This may seem obvious seen that these are all based on the same data. There is, however, a crucial difference. The first results are

built up starting from the data and then going upwards to identify important topics and trends. The second set of results was based on existing theories and then going down in the data to match the data with the theory. The third part put the data in context. The association and resemblance between the sets of results is, therefore, more than a coincidence. It emphasized that the trends found were real trends that appeared in the press. The resemblances in the results of the three analyses are most manifest in the start and end period of the integration process. In the start period, the sense of urgency for the integration was large with clearly the debt issue and the governmental pressure. In the last phase, there is room for research, new management initiatives, and quality of care of the patients. In the mid period of the integration process, and especially in the years 2003 and 2004, elements of institutional, transaction cost and resource dependency paradigms were all used in the press to motivate the integration. Unions were also more mentioned in that period, as well as the word 'network'. In that period, uncertainty among staff about the new organizational form, might have resulted in different rationales put forward in the press. Remarkably, stakeholder-based motivations become only dominant after resource dependency, the learning process, transaction costs, and institutional pressure dominated.

Similar to what could be observed in other European countries, Antwerp government was convinced of the economic rational of larger hospitals and forced the hospitals to integrate and merge using financial reasons as arguments (Azevedo and Mateus, 2014, Gaynor et al., 2012). Hence, a mainly political decision is explained in the press by transaction cost arguments. In the ZNA case, collaboration among the hospitals was thus not a voluntary choice but mandated by the government. The hospitals were heavily criticized for the large debts that they created and only through complying with the institutional demands the

hospitals could obtain legitimacy again. According to Chu and Chiang (2013), efficiency is a good argument for strategic alliances among hospitals. However, there is no guarantee that financial conditions will improve through organizational restructurings (Gaynor et al., 2012, Harrison, 2011). In our case study, financial situation did improve or at least further expansion of the debts was avoided.

The arguments used to initiate the integration process are thus very similar to arguments used in other hospital restructuring processes in other counties (Azevedo and Mateus, 2014; Chu and Chiang, 2013; Gaynor et al., 2012; Weil, 2010). However, previous studies have not focused on how the motivations evolved over a ten years integration process. Van Raak et al. (2005) revealed that institutional theory is clearly dominant in explaining collaboration among care providers, although the other paradigms have their relevance as well. Barringer and Harrison (2000:367) stated in their review that ``*each paradigm alone is insufficient to capture the complexities of inter-organizational relationship formation''.* Our data indicated that all five motivational paradigms were used but not simultaneously. The idea of a more holistic view on the traditional paradigms was further explored by Lowensberg (2010). Given, the length and magnitude of the integration process of ZNA, one paradigm might not have sufficed to explain the different steps in the integration. Our data doesn't confirm Barringer and Harrison (2000)'s distinction between economic versus behavioral arguments. Behavioral and economic paradigms were used simultaneously, e.g., transaction cost theory and institutional theory. There is also a difference with Lowensberg (2010) because not all paradigms are equally important in a given time span. In some semesters, some paradigms are not present at all. Hence, if our study would have been limited to a short period of time, a bias would occur because certain paradigms might be absent and the dominating paradigm

might be only dominant in the press for a short period of time. The results of our research showed evolutions over time that are unaccounted for in previous literature. Although elements from all the presented paradigms may be used as motivations to form a network, the time-span in which these are used differs. Through the process of integration, different paradigms were used sequential but also partly overlapping with a certain evolution from institutional and economic pressure to more stakeholder driven arguments. When time elapses, the focus slides from one motivation towards the next. This doesn't mean the previous paradigms are not present anymore. Some remain present, but since their goal is at least partially achieved, the focus needs to move further on to legitimize next steps. Literature already indicated that networks evolve and that during this evolution different motivations are dominantly used (Lowensberg, 2010, Provan et al., 2011). Our findings confirm this evolution, but fine-tune the model by representing it as a forward moving process. Here the merger was motivated first with the institutional and transaction cost arguments but, depending on the specific case, other paradigms might come first. The integration process took almost a decade requiring new paradigms in each of the steps in the process to explain differences in the steps but also because new arguments were required to be able to explain why the integration needed to go further and even that far that only one large organization would remain.

Interesting is that quality of health care was not used in the press in the starting phase as argument in favor or against the integration process. Demers (2013), however, showed that mergers cannot facilitate integrated care if enforced and can even create bureaucratization, standardization, conflicts and distrust. In the first years of the ZNA case, there was clearly a sense of urgency, making it easy to explain the integration with the institutional and

transaction costs paradigms. However, after the first four years a sense of urgency was less present and other paradigms were needed to legitimize the integration. The case could be seen as one process of solving problems, first the debts, then rationalizing through collaborating and merging, and then improving quality. Transition from one paradigm to another occurred when the most urgent problem was solved and a next problem could be faced. However, transition to another paradigm might also have been necessary because the initial paradigms lost their power in explaining the merging process because the hospitals were saved from bankruptcy. Convincing stakeholders that the merger will benefit them, is a paradigm that only received attention when the other paradigms seemed to have lost power and new ones were needed to explain why the integration process was still going. This confirms a study of Gaynor et al. (2012) on 'merger mania in the English NHS'. They found that many of the arguments used to legitimize mergers in healthcare to the public were not reflecting real reasons or real benefits, even on the contrary, patients did not benefit and even financial performance did not improve. The study of Comtois et al. (2004) on hospital mergers in Quebec reveals the artificial efforts made to legitimize hospital mergers. Politics were heavily influencing the merger process but these arguments were not explicitly mentioned. Also Weil (2010) mentions political arguments for hospital mergers that are hidden behind the typical stakeholder and efficiency arguments.

The power of the media should not be neglected in the legitimization process of a large merging process (Kuronen et al., 2005; Hellgren et al., 2002; Vaara and Tienari, 2002), especially when it concerns hospitals visited by many people and financed by public means. How and how well this is legitimized and motivated might be important in the success of the mergers. A failed legitimization process might have stopped the process or willingness to

spend public resources. Moreover, through the motivations displayed in the press articles, expectations of the public are created or confirmed (Kuronen et al., 2005). Managers should be aware of these expectations to avoid conflicts between expectations of the public and true deliveries of the organization. For instance, when stakeholder arguments are used and patients are, based on what they read in the papers, expecting improved care, such expectations should be met or the merged organization might get heavily criticized losing its legitimacy and maybe its government support. Other stakeholders as well, such as employees, might get influenced by what they read in the media. Management might want to actively inform the media to get grip on this legitimization process in the media and to make sure motivational paradigms match real or intended situations and evolve with the changing situation in the integration process (Hellgren, et al., 2002). This is in agreement with the conceptual paper by Lowensberg (2010) that suggests that managers need to pay attention to several issues of alliances reflected in different paradigms. This can be extended to the fact that managers do not only need to pay attention to the motivations in their decision-making but also in the use of motivational paradigms in the legitimization in the media.

Conclusions

Although there are several articles written about inter-organizational relationships and restructuring within the healthcare setting, very few of them focused on the evolution of these relationships over time, nor on the evolution in legitimizing the relationships. Because of its tumultuous evolution over the last decade, the case of ZNA is a very interesting setting to study the evolution of a healthcare network over time. The case teaches us that all kind of

motivations, such as financial, stakeholder pressure, medical and operational, or legal were used to motivate inter-organizational cooperation and a process ending in a large hospital merger. However, motivations evolve over time with more institutional and transaction costs based motivations legitimizing co-operation at the beginning. Our study contributes to the existing literature on mergers in healthcare, motivations for collaboration and network formation and role of media. First, our results confirm that hospital mergers and restructuring are urged by governments but explained by numerous rationales for which there is little evidence (Azevedo and Mateus, 2014), with the stakeholders benefits as being one of the last used argument. Second, the results contribute to the theory on motivational paradigms (e.g. van Raak et al., 2005) by indicating that these need to be studied over a period of time. Furthermore, although multiple paradigms are used to motivate one restructuring process, these are not fully simultaneously used, nor sequentially. The arguments are used in a semi-overlapping manner in which new arguments are developed semi-overlapping old arguments. Third, the results confirm the role of the printed press in explaining the reasons behind integration and merger processes creating a legitimation story around a political decision (Azevedo and Mateus, 2014, Vaara and Tienari, 2002). Knowing how a certain media channel develops a story is also useful for hospital managers and policy makers.

Limitations

The study is a single case study of a Belgian healthcare organization and, therefore, empirical generalizations cannot be made. A larger scale study, including multiple cases of similar hospital integrations and mergers, is required to confirm the patterns found. The case was

unique because of its scale and time frame. The integration process included seventeen organizations and took almost ten years. Nonetheless, the case can add theoretical contributions that have implications for other settings. The evolutions and institutional context in the healthcare sector in Belgium are similar to those in the sector in Europe, such as pressure to increase scale in health care (Gaynor et al., 2012) and, therefore, the results are relevant for other networks and mergers in the healthcare sector in other European countries. The results might have relevance for other sectors as well because the perceptions of the legitimization process were not specific for healthcare organizations. However, the large government impact was important in our results, and thus the results are mainly relevant for other government controlled sectors. The theoretical contribution to the model of Barringer and Harrison (2007) is useful for any further research on motivational paradigms and perceptions of mergers. Of course, every process of integration and merging will be specific with other paradigms dominating in different periods. Although the evolution of paradigms needs to be confirmed with future studies, we expect that such evolution might occur in other settings but with the paradigms in another order of appearance. Here the integration process clearly departed from financial problems, while other cases might depart from other problems, such as quality issues or lack of staff. It would be interesting to see whether stakeholder and quality of care are motivational arguments that are expressed always in later stadia when other arguments have been used.

The results are based on the communication around ZNA in the printed press and, therefore, lie closer to the data then other models found in the literature. However, data consist of opinions, interpretations, and perceptions expressed in the media; and not of motivations of different stakeholders collected through interrogating these stakeholders or to collect data

of printed press for particular groups of stakeholders, such as publications for nurses or doctors. Hence, a limitation that needs to be clearly mentioned is that only printed press oriented towards the general public is included. Our data did not allow to measure who influenced the dominant voices in the press and it might be the loud voices of a minority superseding the silent voices of the majority. Disregarding who influenced the press, the general public is influenced by these opinions in the press. Data generate a holistic view instead of in-depth knowledge of the dynamics taking place in the processes of the collaboration. Such insight requires another method and was, therefore, out of scope of our study. However, it would be an interesting addition to our study to see if these motivations were also perceived by the different stakeholders of the network, such as patients or employees.

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References

Acevedo, B., and R. Common.2006 "Governance and the management of networks in the public sector." *Public Management Review,* **8** (**3**): 395-414.

Antunes, V., and P. J. Moreira.2011 "Approaches to developing integrated care in Europe: a systematic literature review." *Journal of Management & Marketing in Healthcare,* **4** (**2**): 129-135.

Arnaert, A., B. Van Den Heuvel, and T. Windey.2005 "Health and social care policy for the elderly in Belgium." *Geriatric Nursing,* **36** (**6**): 366-371.

Auld, G. W., A. Diker, A. Bock, C. J. Boushey, C. M. Bruhn, M. Cluskey, M. Edlefsen, D. L. Goldberg, S. L. Misner, B. H. Olson, M. Reicks, C. Z. Wang, and S. Zaghloul.2007 "Development of a decision tree to determine appropriateness of NVivo in analyzing qualitative data sets." *Journal of Nutrition Education and Behavior,* **39** (**1**): 37-47.

Azevedo, H., and C. Mateus.2014 "Cost effects of hospital mergers in Portugal." *European Journal of Health Economics,* **15** (**9**): 999-1010.

Baker, C. M., Ogden, S. J., Prapaipanich, W., Keith, C. K., Beattie, L. C., & Nickleson, L. E.1999 "Hospital consolidation: applying stakeholder analysis to merger life-cycle." *Journal of Nursing Administration*, **29(3)**: 11-20.

Barringer, B. R., and J. S. Harrison.2000 "Walking a tight rope: Creating value through interorganizational relationships." *Journal of Management,* **26** (**3**): 367-403.

Beech, R., C. Henderson, S. Ashby, A. Dickinson, R. Sheaff, K. Windle, G. Wistow, and M. Knapp.2013 "Does integrated governance lead to integrated patient care? Findings from the innovation forum." *Health & Social Care in the Community,* **21** (**6**): 598-605.

Burns, L. R., and M. V. Pauly.2002 "Integrated delivery networks: A detour on the read to integrated health care?" *Health Affairs,* **21** (**4**): 128-143.

Burns, L. R., and M. V. Pauly.2012 "Analysis & Commentary: Accountable Care Organizations May Have Difficulty Avoiding The Failures Of Integrated Delivery Networks Of The 1990s." *Health Affairs,* **31** (**11**): 2407-2416.

Carruthers, J., Ashill, N. J., & Rod, M.2006 "Mapping and assessing the key management issues influencing UK public healthcare purchaser-provider cooperation." *Qualitative Market Research: An International Journal*, **9(1)**: 86-102.

Chu, H.-L., and C.-Y. Chiang.2013 "The effects of strategic hospital alliances on hospital efficiency." *Service Industries Journal,* **33** (**6**): 624-635.

Cohen, D., and D. A. Levinthal.1990 "Absorptive capacity: A new perspective on learning and innovation." *Administrative science quarterly,* **35**: 129-152.

Comtois, E., J.-L. Denis, and A. Langley.2004 "Rhetorics of Efficiency, Fashion and Politics." *Management Learning,* **35** (**3**): 303-320.

Currie, G., R. Finn, and G. Martin.2008 "Accounting for the 'dark side' of new organizational forms: The case of healthcare professionals." *Human Relations,* **61** (**4**): 539-564.

Demers, L.2013 "Mergers and integrated care: the Quebec experience." *International Journal of Integrated Care,* **13** (**February**).

Garcia-Pont, C., & Nohria, N.2002 "Local versus global mimetism: The dynamics of alliance formation in the automobile industry." *Strategic Management Journal*, **23(4)**: 307-321.

Gaynor, M., M. Laudicella, and C. Propper.2012 "Can governments do it better? Merger mania and hospital outcomes in the English NHS." *Journal of Health Economics,* **31**: 528-543.

Gerkens, S. and S. Merkur.2010 "Belgium Health system review." The European observary series: Health systems in transition, **12(5)**, 301p.

Gloede, T. D., J. Pulm, A. Hammer, O. Ommen, C. Kowalski, S. E. Gross, and H. Pfaff.2013 "Interorganizational relationships and hospital financial performance: A resouces-based perspective." *Service Industries Journal,* **33** (**13-14**): 1260-1274.

Goodwin, N.2013 "Understanding integrated care: a complex process, a fundamental principle." *International Journal of Integrated Care,* **13** (**March**).

Grafton, J., M. A. Abernethy, and A. M. Lillis.2011 "Organisational design choices in response to public sector reforms: A case study of mandated hospital networks." *Management Accounting Research,* **22** (**4**): 242-268.

Harrison, T. D.2011 "Do mergers really reduce costs? Evidence from hospitals." *Economic Inquiry,* **49** (**4**): 1054-1069.

Hellgren, B., J. Löwstedt, L. Puttonen, J. Tienari, E. Vaara, and A. Werr.2002 "How issues become (re)constructed in the media: Discursive practices in the AstraZeneca merger." *Britisch Journal of Management,* **13**: 123-140.

Johar, M., and E. Savage.2014 "Do Mergers Benefit Patients in Underperforming Administrations? Lessons from Area Health Service Amalgamation." *Economic Record,* **90** (**291**): 526-535.

Kristensen, T., K. R. Olsen, J. Kilsmark, J. T. Lauridsen, and K. M. Pedersen.2012 "Economies of scale and scope in the Danish hospital sector prior to radical restructuring plans." *Health Policy,* **106** (**2**): 120-126.

Kuronen, M. L., J. Tienari, and E. Vaara.2005 "The merger storm recognizes no borders: An analysis of media rhetoric on a business manoeuvre." *Organization,* **12** (**2**): 247-273.

Lim, K. K.2014 "Impact of hospital mergers on staff job satisfaction: a quantitative study." *Human Resources for Health,* **12**.

Lowensberg, D. A.2010 "A new view on traditional strategic alliances' formation paradigms." *Management Decision,* **48** (**7**): 1090-1102.

Mur-Veeman, I., & Govers, M.2011 "Buffer management to solve bed-blocking in the Netherlands 2000–2010. Cooperation from an integrated care chain perspective as a key success factor for managing patient flows." *International journal of integrated care*, **11(Special 10th Anniversary Edition)**.

Page, C. G.2002 "The determination of organization stakeholder salience in public health." *Journal of Public Health Management and Practice*, **8(5)**: 76-84.

Provan, K. G., J. E. Beagles, and S. J. Leischow.2011 "Network formation, governance, and evolution in public health: The North American Quitline Consortium case." *Health care management review,* **36** (**4**): 315-326.

Riad, S., E. Vaara, and N. Zhang.2012 "The intertextual production of international relations in mergers and acquisitions." *Organization Studies,* **33** (**1**): 121-148.

Rummery, K.2009 "Healthy partnerships, healthy citizens? An international review of partnerships in health and social care and patient/user outcomes." *Social Science & Medicine,* **69**: 1797-1804.

Thier, S. O., W. N. Kelley, H. Pardes, A. W. Knight, and M. Wietecha.2014 "Success Factors in Merging Teaching Hospitals." *Academic Medicine,* **89** (**2**): 219-223.

Thomson, E., J. Farmer, J. Tucker, and H. Bryers.2008 "Informing debate or fuelling dispute? Media communication of reconfiguration in Scotland's rural maternity care." *Social Policy & Administration,* **42** (**7**): 789-812.

Vaara, E., and P. Monin.2010 "Recursive perspective on discursive legitimation and organizational action in mergers and acquisitions." *Organization Science,* **21** (**1**): 3-22.

Vaara, E., and J. Tienari.2002 "Justification, legitimization and naturalization of mergers and acquisitions: A critical discourse analysis of media texts." *Organization,* **9** (**2**): 275-304.

Vaara, E., and J. Tienari.2011 "On the Narrative Construction of Multinational Corporations: An Antenarrative Analysis of Legitimation and Resistance in a Cross-Border Merger." *Organization Science,* **22** (**2**): 370-390.

Vaara, E., J. Tienari, and J. Laurila.2006 "Pulp and paper fiction: On the discursive legitimation of global industrial restructuring." *Organization Studies,* **27** (**6**): 789-810.

Van Raaij, D.2006 "Norms network members use: An alternative perspective for indicating network success or failure." *International Public Management Journal,* **9** (**3**): 249-270.

Van Raak, A., I. Mur-Veeman, B. Hardy, M. Steenbergen, and A. Paulus 2003 "Integrated care in Europe: Description and comparison of integrated care in six EU countries" In Book Integrated care in Europe: Description and comparison of integrated care in six EU countries. ed. Editor. City: Elsevier.

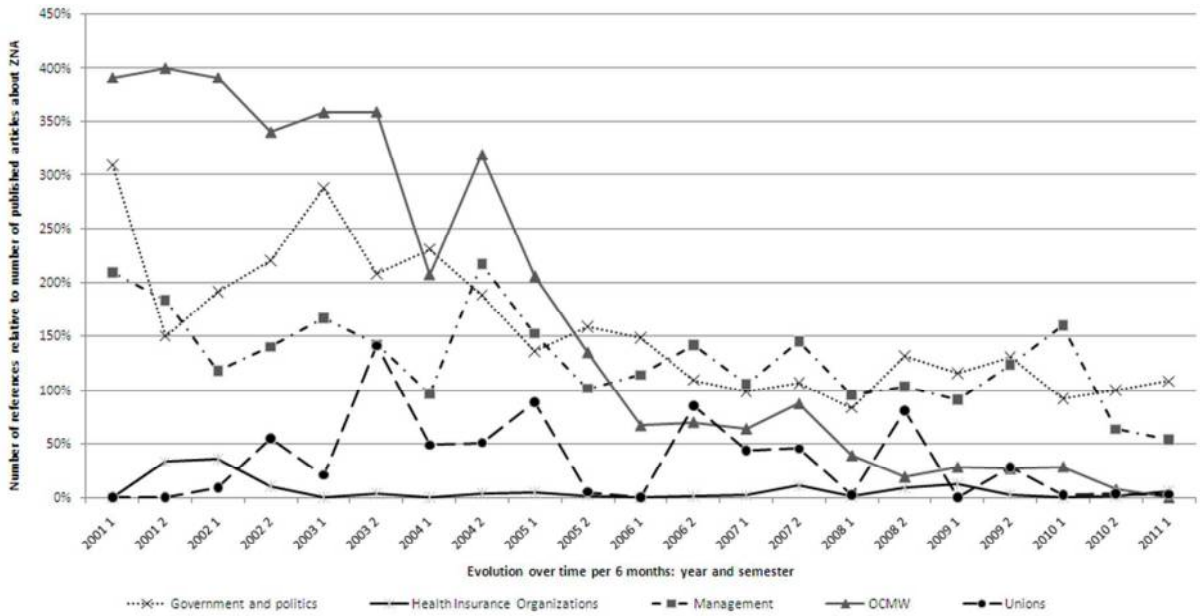
Van Raak, A., A. Paulus, and I. Mur-Veeman.2005 "Why do health and social care providers co-operate?" *Health Policy,* **74**: 13-23.

Vergne, J.-P.2011 "Towards a new measure of organizational legitimacy: Method, validation, and illustration." *Organizational Research Methods,* **14** (**3**): 484-502.

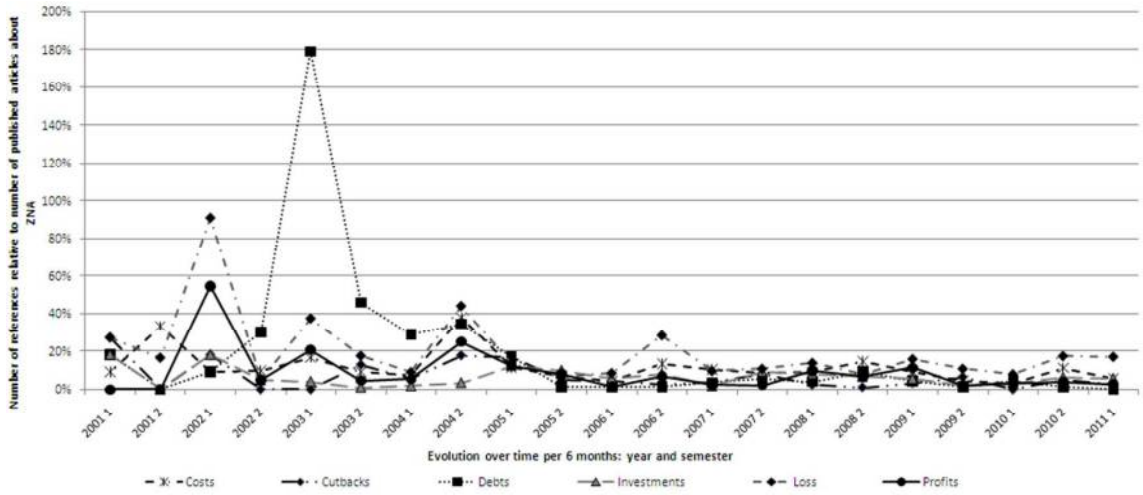
Weil, T.2010 "Hospital mergers: a panacea?" *Journal of Health Services Research & Policy,* **15** (**4**): 251-253.

Yin, R. K. (1994), *Case study research: Design and methods.* Sage: Thousand Oaks, CA.

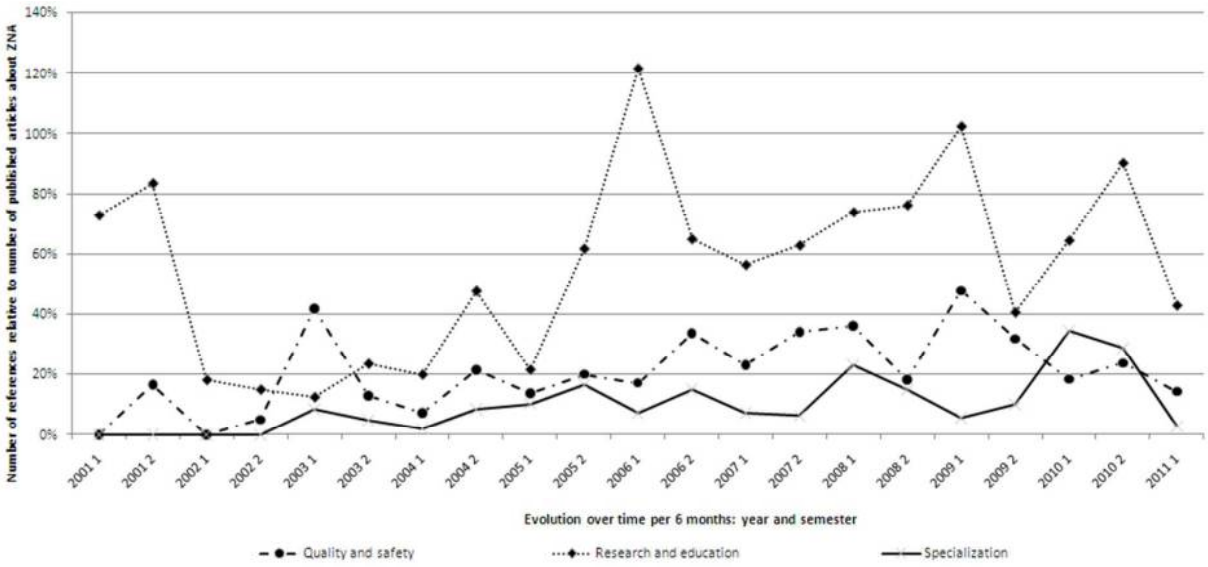
Yu, S.-H., and M.-Y. Chen.2013 "Performance impacts of interorganizational cooperation: A transaction cost perspective." *Service Industries Journal,* **33** (**13-14**): 1223-1241.



Graph 1: Evolution of appearance of codes related to stakeholders

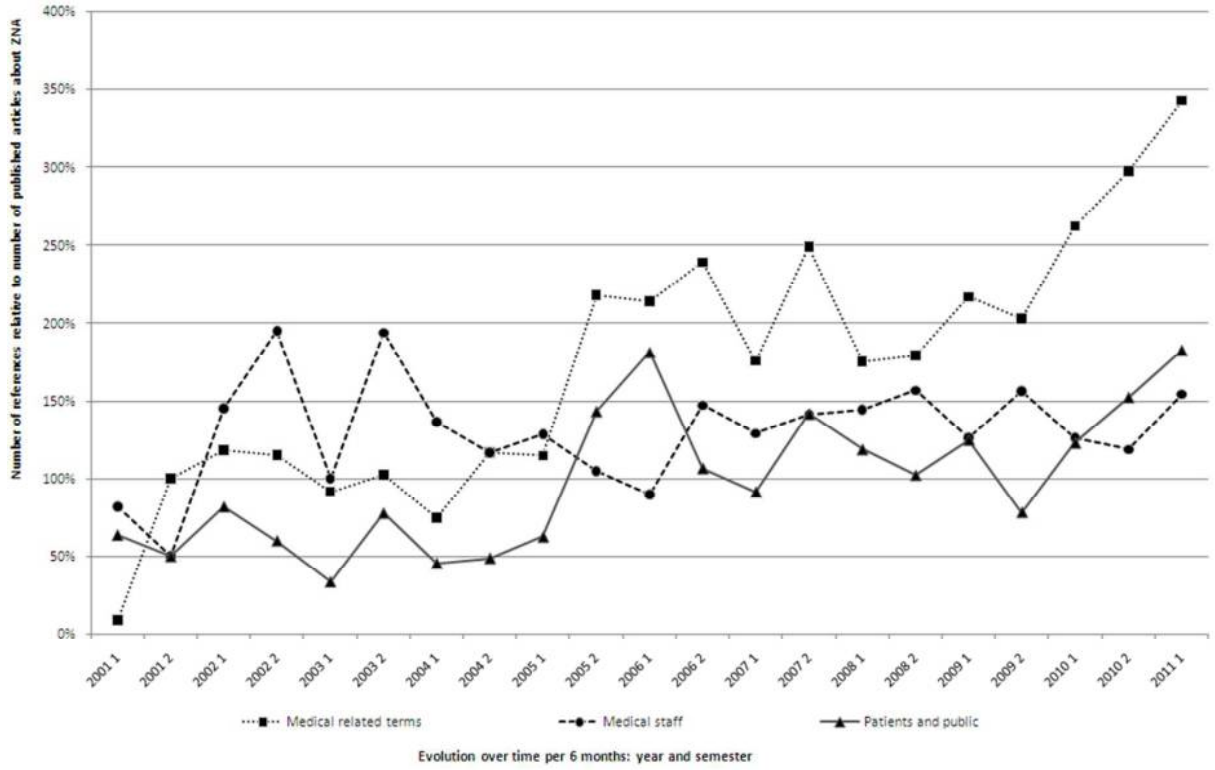


Graph 2: Evolution of appearance of codes related to financial issues.



Graph 3: Evolution of appearance of codes related to quality and specialization.

Graph 4: Evolution of appearance of codes related to medical terms and patients.



Graph 5: Evolution of the paradigms based on the qualitative data coding.