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A strategic document as a tool for implementing change. Lessons from the merger creating the South-East Health region in Norway

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ABSTRACT

In 2007, the Norwegian Parliament decided to merge the two largest health regions in the country: the South and East Health Regions became the South-East Health Region (SEHR). In its resolution, the Parliament formulated strong expectations for the merger: these included more effective hospital services in the Oslo metropolitan area, freeing personnel to work in other parts of the country, and making treatment of patients more coherent. The Parliamentary resolution provided no specific instructions regarding how this should be achieved.

In order to fulfil these expectations, the new health region decided to develop a strategy as its tool for change; a change "agent". SINTEF was engaged to evaluate the process and its results. We studied the strategy design, the tools that emerged from the process, and which changes were induced by the strategy. The evaluation adopted a multimethod approach that combined interviews, document analysis and (re)analysis of existing data. The latter included economic data, performance data, and work environment data collected by the South-East Health Region itself.

SINTEF found almost no effects, whether positive or negative. This article describes how the strategy was developed and discusses why it failed to meet the expectations formulated in the Parliamentary resolution.

1. Background

The literature on hospital mergers reveals that they seldom achieve their goals; more often, they have a negative influence [1–4]. "Political pressure for mergers may be irresistible, but a clear way forward and more support are needed to prevent them causing more problems than they solve" [5]. The merging of the two largest hospitals in Stockholm [6–8] has many similarities with the merger we studied, and the result was not what had been expected. For stakeholders below the top management, the ideas behind the merger were not convincing. Another study, from Denmark, concluded that the effect of merging hospitals had been small or absent [9]. The few positive examples had two things in common: the hospitals were relatively small, and the purpose of the mergers was clearly specified [10].

Against this background, the goals set for the new SEHR were ambiguous. In the Parliamentary resolution the expectations were formulated as follows [11]:

- The overall governance and coordination of patient flows should be improved

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- A more efficient use of resources ought to be implemented
- Increased efficiency should reduce hospital personnel, making them available to other parts of the country;
- Improvements should be made in coordinating research and education.

These results were expected to emerge from changes implemented in the Oslo metropolitan area.

The new management decided it was necessary to develop a strategy as the [main] tool to achieve these goals. Based on our study of the formulated strategy, this article discusses whether the strategy became an 'agent for change'. Section 4 answers the following questions:

1) Did the strategy concentrate on the tasks (changes in the metropolitan area, governance and coordination of patient flows, better efficiency) given by Parliament and Ministry of Health and Care Services?
2) Did the strategy contribute to changes in the organisation?
   a) Which organisational changes resulted from the strategy process?
   b) How did organisational changes affect the organisation?
   c) Did the strategy extend to the lower ranks of the organisation?
3) Did the region meet the goals of the merger, as set out by Parliament and Ministry of Health and Care services?
   a) Was the overall governance and coordination of patient flow improved?
   b) Did efficiency improve?
   c) Did the number of employees in the metropolitan area fall, to the benefit of other parts of the country?
   d) Did research and education improve?

2. Methods

The evaluation adopted a multimethod approach that combined interviews, document analysis and (re)analysis of existing data. The latter included economic data, performance data and work environment data collected by the health region itself.

The document analysis covered all documents presented to the board of the South-East Health Region from its establishment in 2007 to the presentation of the strategy to the hospital trusts in January/February 2009, including supporting documents. For the period 2009–2012, document analysis concentrated on documents concerning central hospital trusts. The Office of the Auditor General of Norway audited the process concerning the Oslo hospitals, which also became part of the document study of the project [12].

The evaluation of economic development and efficiency used data from the Research Council of Norway-financed project: "The effects of DRG-based financing on hospital performance: productivity, quality and patient selection", which used accounting data from 2004 to 2012 for all Norwegian hospitals.

The development of patient activity and quality in patient treatment was studied using register data from the Norwegian Patient Register, which includes personalised records of all hospital visits.

We interviewed top managers, managers in local departments, employees without management responsibility, union representatives and representatives of patient organisations. Interviewees represented both hospitals and departments that had been highly involved in the change process, as well as units that had not experienced any formal or practical change. Sixty-two individuals were interviewed through 36 individual and nine group interviews.

The SEHR gathers annual data on how employees regard their working conditions. These data were analysed to see whether, and how, the process had affected the working milieu.

The focus have been to investigate how the formulated strategy answers the tasks and goals set by the Parliamentary resolution and whether changes after approval of the strategy could be linked to the strategy.

3. The environmental and historical influences on Norwegian hospital services

Following the typology established by Bøhm et al. [13], health care in Norway can be classified as a National Health Service with public actors as service providers supported by strong public funding and regulation. The current hospital system was established in the early seventies by the Hospital Act of 1969 and the Parliamentary resolution that described Norway's regionalised hospital system [14,15]. While all major actors are public, relationships among them have changed over time. This paper focuses on the effects (and non-effects) on the service providers, in this case hospitals, of a major reorganisation initiated by Parliament.

Since the Hospital Act of 1969, Norway's 19 counties have owned the hospitals located within their respective borders. The only exceptions were a state cancer hospital, the National Hospital, which is owned by the state, and a few private non-profit hospitals. The counties cooperated within five designated hospital regions, each having a regional university hospital. Regionalisation was gradually strengthened. In 2002, all public hospitals became state enterprises. Five regional bodies governed the hospital sector as an extension of the Ministry's authority. With the Minister of Health acting as the national hospital board, Fig. 1 provides a description of the hospital sector today.

The hospital trusts administer the individual hospital units within one or two counties.

In three of the regions (West, Mid and North), the regional organisation was straightforward, with a clearly identified and accepted major hospital as the regional hospital. There were rarely several hospitals within the same city, as Norwegian cities tend to be too small.

In Oslo, the situation was different. In 2006, there were four public hospitals, two of which were regional hospitals. The National Hospital was the regional hospital for the South region and the old county hospital of Oslo, Ullevål hospital, was the regional hospital for the East region. Oslo city was part of the East region. The two hospitals are 3 km apart, and have a history of some rivalry and conflicts.

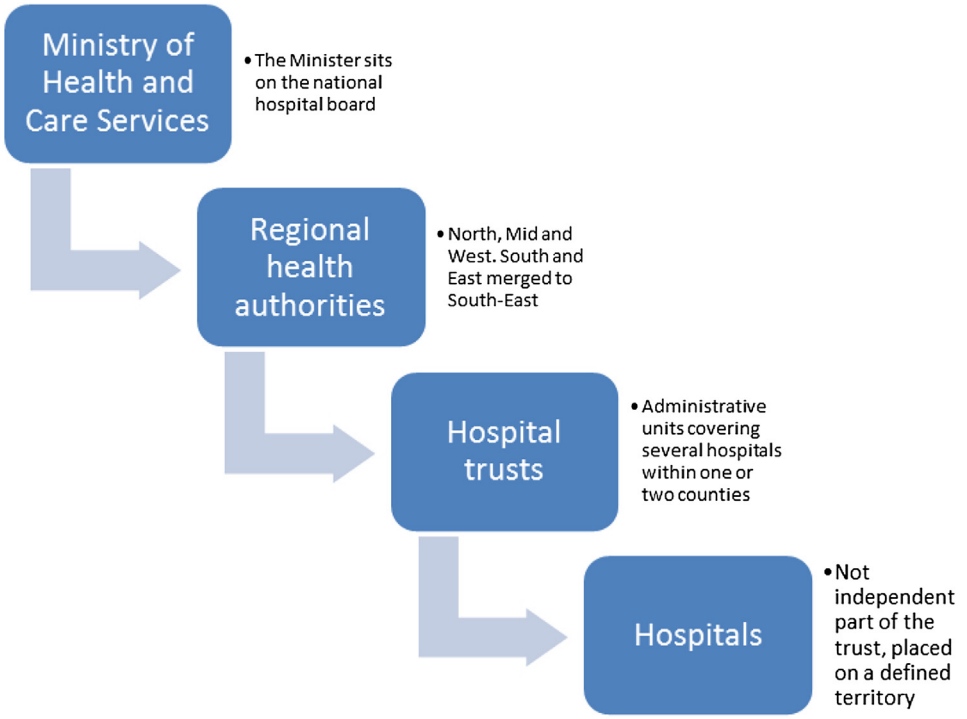

Fig. 1. Norwegian hospital organisation.

There were repeated discussions about patients being the victims of a competence struggle between these two university hospitals [16]. One Minister of Health claimed there was a Berlin wall running through Oslo, dividing the hospitals [17]. To solve this problem, in 2007 the government decided to merge the South and East regions, creating by far the largest health region in Norway, the South-East Health Region. The Ministry of Health and Parliament assumed that with these two hospitals lying within the same region, disputes would end. The expectations articulated in the Parliamentary resolution were probably based on the work of a project group established by the Ministry of Health and Care Services [16] for which McKinsey provided the secretariat, included a paper that claimed that merging the Oslo hospitals could free up almost USD 100 million a year [18].

4. Results

4.1. Did the strategy concentrate on the tasks set by Parliament and the Ministry?

The Parliamentary resolution focused on the Oslo metropolitan area, on patient flow in the somatic sector, efficient use of employees, and research activity. Instead of following this up, the strategy covered the whole SEHR and all services. It was expanded to include psychiatric and abuse services, para-medical services, laboratories and support services, including hospital orderly services, catering, housekeeping, security, health & safety, laundry, management of buildings and facilities, financial departments and human resources. All the trusts and hospitals in the region were involved, not only those situated within the metropolitan area. The main goals of the strategy were to make the services more equal and more available. There were no specific goals regarding efficiency, freeing up of personnel, or a more coherent patient flow in the metropolitan area. An exception was the chapter for research and education. That task was specifically set out in the resolution, and the strategy formulated specific goals for it.

4.2. Did the strategy contribute to changes in the organisation?

The strategy decided to divide the region into six hospital trusts, which should be large enough to provide treatment for 80–90% of the inhabitants in its catchment area, indicating that 10–20% would normally have to go outside of the area to seek more specialised care. Each trust should have a single main area hospital, and a number of local hospitals. Following this decision, the smallest trust was dissolved, its three hospital units were transferred to neighbouring trusts, corresponding to the county in which the hospitals were located. Two counties, Telemark and Vestfold, formally became one trust, but the two hospitals, Vestfold hospital and Telemark hospital maintained their independence as hospital trusts. Originally, the county around Oslo was one hospital area. Now the west side municipalities were moved into Vestre Viken hospital trust, with their local hospital. The east side remained a hospital trust, and two districts within Oslo

became part of its responsibilities. The rest of Oslo remained a hospital trust, and the four public hospitals were merged into one organisational unit under the name of Oslo University Hospital Trust (OUH). OUH then decided to downsize one of the four hospitals and move its services to the former Ullevål Hospital and the National Hospital. Three trusts did not experience any organisational change. One new trust, covering Telemark and Vestfold counties, existed only on paper; the two hospitals carried on as before. The aim of serving 80–90% of inhabitants within a given area (trust) was identical to the reality before the strategy began to take shape.

4.3. Did organisational changes lead to other changes?

Protagonists who work with strategic formulation all agree on one essential aspect of the process: management must embrace the strategy. Through our interviews, the only wholehearted support for the strategy came from the CEO who started the process. Other respondents were less supportive. The CEO's first hand was eager to point out all the modifications associated with the goals. The CEO of one trust said that *"the visions (of the strategy) could support any organizational structure"* [19].

Some of the important decisions taken by the new OUH board were only implemented because the chair used his casting vote [20]. The current CEO of OUS has explicitly stated that he never read the SEHR strategy [21]. Employees at lower levels in the organisation claimed that key decisions were taken before they were invited to participate. It is important to mention that no-one interviewed actually opposed strategy and central goals as such. The medical managers of the trusts in particular regarded the quality goals as a support in performing their duties, but they did not connect them with the strategy. They related the goals to the annual commission from the Ministry and by the Minister of Health's own public pronouncements in newspapers and on television/radio. We found little direct opposition to the strategy but nor was there any strong support; rather we registered indifference and a lack of knowledge of what the strategy actually was. The formal changes did not lead to any observable change in how the trusts performed.

4.4. Implications for the lower reaches of the organisation

We were eager to see if the strategy affected the employees in terms of how much they were affected by the strategy in their day-to-day work. The merging of the Oslo hospitals in particular was widely discussed in public [22].

Before the merger in 2007, both health regions assessed the work environment of all their employees annually. The questionnaires employed were based on well-known psychosocial theories such as the Demand–Control model of Karasek [23] and questionnaires such as QPS Nordic [24]. They employed staff who were specialists on these methods and who carried out validation analysis, as well as assisting in gathering and interpreting the data. However, there were both major and minor differences between the health regions regarding what information they requested. Therefore, following the merger, the new region harmonised the work environment survey. This process took a year, and in 2009, no surveys were carried out. The survey in 2010 did not include the new Oslo University Hospital, due to its recent merger. However, six indices were developed, based on two to four items each. These were identical in all units from 2008 until 2013. Below we display the scores in the period 2008–2013 for these six indices (Fig. 2).

We normalised the work environment indices and ranked them from 0 to 100, where in all cases a higher score indicates a better result. What is important here is not the exact score for each index, but rather the stability of the situation as a whole. There are really no differences over the years when looking at the whole health region. This top-level picture could mask differences at lower levels; the work environment of some units could have worsened while others might have improved as a result of the same changes. To assess this, we analysed what happened at unit level, fairly low in the hierarchy. There could be five levels from bottom level to top. The total number of employees in the SEHR is close to 80,000. There were several thousand identifiable individual units, in which a significant percentage experienced change annually. However, when we took the 2011–2013 as a sample, we were able to compare all units within SEHR on 72 items in 15 indices.

In order to determine whether the strategy had particularly influenced certain departments or hospitals, we selected a number of hospitals that had experienced changes and others that had not. Within OUH, some departments merged before the strategy process started, while others were strongly influenced by the process.

We found no unit whose work environment systematically deteriorated or improved. Overall, the conclusion was straightforward; the merger did not affect working environments within SEHR.

OUH supplemented the annual questionnaire described above with questions about how employees assessed the merging of Oslo's hospitals. Less than 30% believed that the intention behind the mergers has been fulfilled. Three years after the merger, only between 40 and 50% said yes to the same question. Despite this low level of belief, 70–80% of OUH staff responded that they enjoyed working in their department, and this percentage was constant through the period studied. Comparing answers over time for each unit and differences between the units, we found no differences and no changes related to the strategy process. On most of the topics, such as job satisfaction and motivation, the positive answers rated from 75% to 88%, which must be regarded as high score. The lowest scores were for self-assessment, which rated 46% and workload with 63%.

An unexpected finding was the large number of organisational changes that were taking place independently of the strategic process. Every year, a number of units would disappear and new units appear (Table 1). Organisational change is the normal situation, whether strategic processes are being implemented or not. Ahus was adapting to a completely new hospital building in the period, as is reflected in the table. Even the most stable hospital trusts had changes ranging from 6 to 24 per cent in each of these three years.

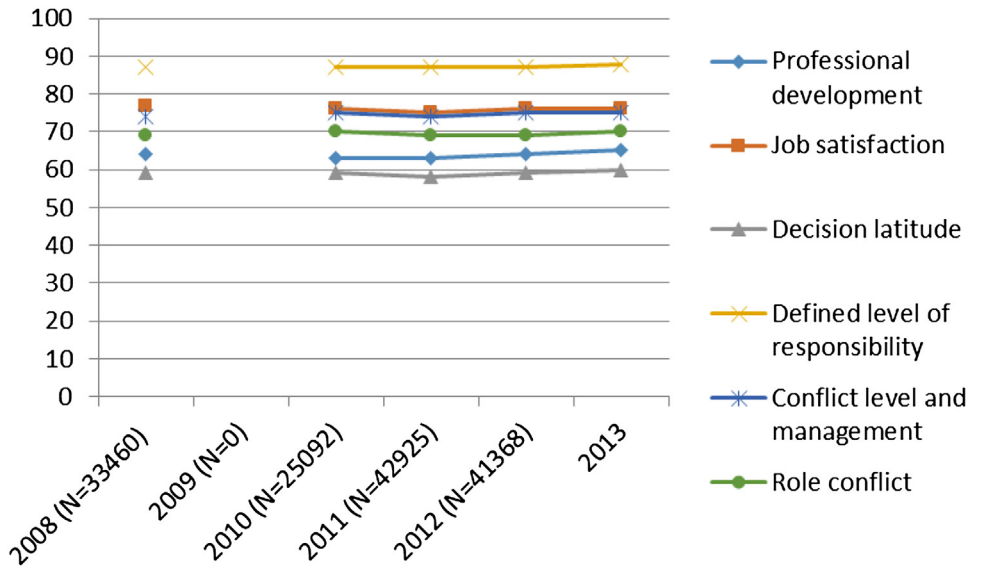

Fig. 2. Work environment score in SEHR from 2008–2013; entire health region. Index score normalised from 0 to 100 (max).

Table 1
Number of organisational changes 2011–2013. "Ended" refers to units closed down and "New" to units created in the course of this period; percentage relates to the baseline each year.

	2010			2011			2012			2013
	Baseline	New	Ended	Baseline	New	Ended	Baseline	New	Ended	Baseline
Ahus	238	12%	37%	179	54%	51%	183	9%	50%	108
OUH	NA	NA	NA	1 031	3%	7%	992	4%	10%	928
Hospital trust of Telemark	244	7%	9%	239	14%	13%	242	1%	4%	236
Hospital trust of Vestfold	229	10%	4%	242	9%	10%	239	4%	3%	241
Hospital trust of Vestre Viken	337	15%	8%	359	11%	13%	350	2%	4%	341

4.5. Did the region meet the goals for the mergers set by Parliament and Ministry of Health and Care Services?

The goals for the merger were better efficiency, better patient coordination of patient flow and better results in the area of research and education.

In order to study the development of economic efficiency we analysed the productivity of somatic hospitals for the period 2004–12. We analysed the effect of the merger by looking at how developments in SEHR had been, compared to the other regions in the periods 2007–12, 2008–12 and 2009–12 [25]. Data envelopment analysis (DEA) was used together with bootstrapping to estimate confidence intervals [26]. Both constant and variable return to scale were used [27]. We found no systematic differences (Fig. 3).

One specific goal that was set out in the Parliamentary resolution was to reduce the number of hospital personnel in the metropolitan area so that they could become available to other parts of the country. The result was the opposite. The number of employees in OUH and Ahus increased by 1700 from 2010 to 2013.

Studying activity and quality, we compared the development of the most common parameters; inpatients, day patients and outpatients, bed days and length of stay. Norway registers a set of quality parameters both for somatic and psychiatric care, such as number of corridor patients, infection rates, waiting lengths before treatment, etc., which we analysed. In the course of the period, the performance of the regional trusts moved closer to each other. In 2013 waiting times were 70–75 days, out patients visits per 1000 inhabitants were 900, 7% of operations were postponed and infection rates were 5%. Fig. 4 describes the numbers of patients in the four regions in the period analysed.

We also studied how the region worked with different national projects that were trying to improve the quality of treatment. The results were similar to the productivity study. The development did not diverge from the time before the strategy process or with the development in the other health regions.

The long-term goal for the South-East Health region is to put five per cent of its budget into research. In the period after the strategy process, it reached 2.8%, which was above the goal for that period. Compared to other health regions, points for scientific publications displayed a positive development. The region's share of points rose from 59.6 to 62.6% of the total for all four Norwegian health regions.

5. Discussion

5.1. The profile of the strategy

The final strategy document [28] describes all the positive goals for the regions' patient treatment, the

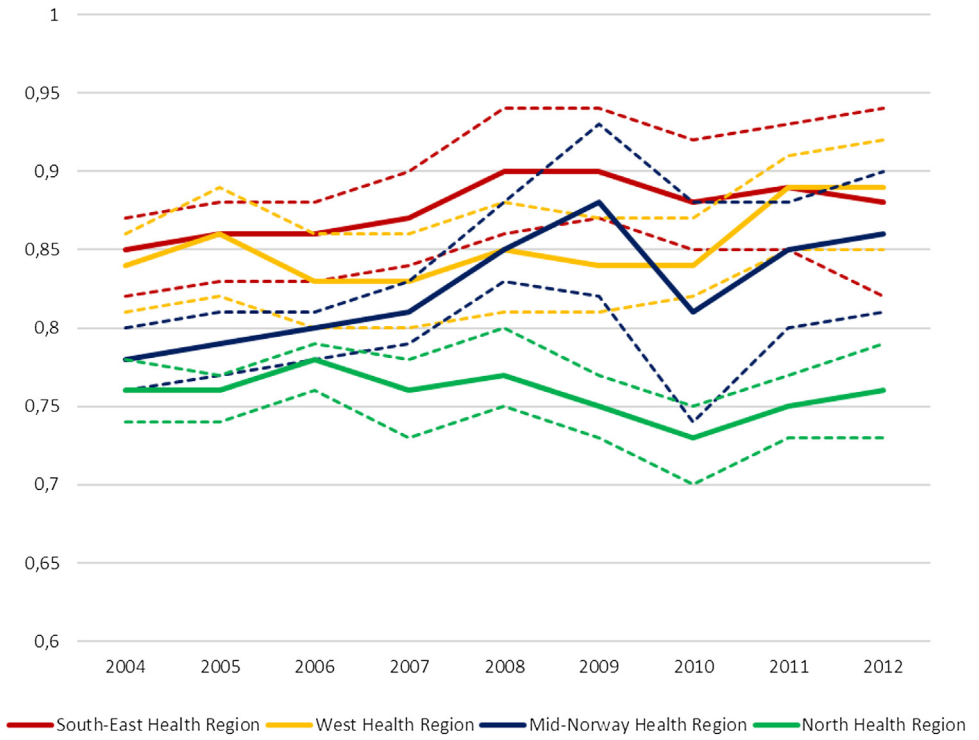

Fig. 3. Average level of productivity in each health region, model: constant return to scale, and outpatient activity measured as number of consultations, bootstrapped estimate with 95% confidence interval.

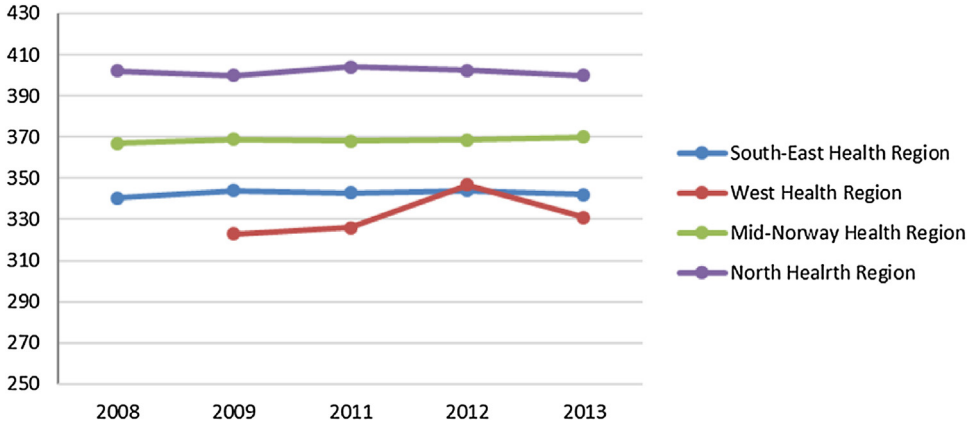

Fig. 4. Patients per 1000 inhabitants per health region 2008–2013.

Source: SAMDATA.

involvement of employees and a sustainable economic performance, but there is no analysis of where the region is performing below expected standards and where it is performing above them. Documents and reports leading to the final document neither discuss nor analyse these topics. An early document stated that the strategy should "concentrate on implementation rather than investigation" [29]. It is probably correct to say that it failed in both respects. The demanding character of mergers was underestimated. The statement by Charlesworth, chief economist of the Nuffield Centre, is representative of the documented experiences. "Merging healthcare organisations should be viewed with caution, unless there are clear and demonstrable benefits to patient services" [30]. In 2013 the Competitions Commission in NHS in England blocked a merger between Bournemouth hospitals because they could not prove any gain for patients [31]. The strategy took a cautious stand resulting in few and weak changes. Making the strategy covering 'everything' it evaded the hard tasks. It was general and not a tool for change.

The notion of the "Berlin wall" running through Oslo was probably the one statement that most strongly lead to the merger, and in our interviews [32] quite a few persons expressed the view that cooperation between the Oslo

hospitals needed to be better. In spite of this, neither the Ministry of Health and Care Services nor the SEHR investigated where the problems were concentrated and how many patients were involved. Such a study could have brought them closer to the desired change.

The Parliamentary resolution is clear on specifying efficiency goals, and in our introductory meeting with the SEHR management this economic argument was stated by the CEO as an important part of our mandate [33]. That was the last time in our study that any high-ranking official used economic gain as an argument for the merger. One central person in the Ministry's project group that had suggested the merger, told us that her concern was that it could cost more than expected; she had never believed in any economic gain [34]. That contrasted with the report [35] she had delivered in 2004, which stated that economic gain was an important goal. This denial of having economic efficiency expectations for the merger came some years after the merger was a reality, with the benefit of hindsight. How strong the belief was before the merger we do not know, but the CEO of the new region stated: "My opinion is, and has always been that when Parliament has issued a clearly expressed directive, then we carry it through" [36]. By making the strategy so wide-ranging and general, it became possible to move away from the original specific goals. The regional management acted as Ole Berg [37] states bureaucrats do; "They will always look backward not forward. He or she is in search for precedency and does not try to estimate substantial consequences."

If the merger had met Parliament's expectations, it would have been unprecedented in the Norwegian history of hospitals and almost in direct contrast to experiences with hospital mergers internationally [38–42]. In particular, there were no previous examples in Norway of achieving a reduction of personnel. Attempts to make hospitals more efficient often lead to political and public debate. Therefore, it should be no surprise that active support for such an attempt was weak, even within the Ministry inducing the merger. An option for the SEHR management could have been to discuss more closely with their principal (the Ministry) what was a realistic goal for economic gains, and what timespan would be necessary to reach them?

In contrast to such an approach, the strategy ended up with goals very close to those formulated for Norwegian hospital services through the commission delivered by the Ministry of Health every year. The differences were somewhat cosmetic. While the aim of the Norwegian health services is to be equal and accessible, the main goal for the new strategy was to be *more* equal and *more* accessible. The strategy formulated the virtues that should pervade the services, but not specific goals to be met. The SEHR management now calls the strategy a reform of direction [43], but no direction was pointed out; the reform was rather a vision of good intentions.

5.2. Organisational changes

The organisational changes were formal and not connected to any specific desired change. In the interview with the new CEO of SEHR in 2013, he stated that if one thing from the strategy process would survive, it would be the creation of hospital areas [20]. That was the new name for the trusts. As discussed in Section 4, the practical changes were formal, and the mission formulated for the new hospital areas (trusts) did not change. The greatest change occurred in the Oslo hospital area (trust). The four public hospitals merged, appointing one CEO. However, that was the whole, the appointment of a new CEO. Neither this new CEO nor any of the other CEOs of the trusts were given specific orders regarding fulfilment of the strategic goals. For decades, the Ministry had been troubled by stories of non-cooperation between the two largest hospitals in Oslo. During all these years, the head of all Norwegian hospitals had been the Minister. In our investigation we have found no discussion of how a merger, first of the South and the East region and then of the Oslo hospitals could change this situation. The chief manager, the Minister of Health, was the same. The management at the next two levels below was changed. The CEOs were given no new tools to use, either formal or economic. The results were meagre. The first CEO of Oslo University Hospital had been part of the Ministry project group that proposed the merger of the two regions. After only a few months in the chair, she became the most articulate and powerful counterpart to the SEHR management. She resigned after two years. The SEHR management did not ensure that the CEO of the by far largest hospital trust became a supporter of the strategy. As described in the Section 4, the strategy had little active support even in the inner circles of top management.

5.3. Reaching out to the lower levels of the organisation

Our findings give a picture of an organisation where the different units are somewhat independent of changes in the layers above. There is a vast literature describing how medical care markets differ from standard markets [44], and this may be reflected in how the organisation reacts to reorganisation. Degeling et al. describe how doctors, and even medical managers, were characterised as individualistic, non-hierarchical and patient-centred, in contrast to managers who were hierarchical and systematically team-centred [45], i.e."…, the medical staff and administration are locked in a noncooperative oligopoly-type game" [46]. A project that interviewed 30 clinicians becoming managers in the middle and first-line of a hospital, reveals that they were mostly appointed by fellow colleagues, often the former leader of the unit [47]. This project underpins the description that the lower units of a hospital are largely independent of higher levels. If a strategy is to reach out to this part of the hospital, it must be translated into local settings, making it relevant to them [48].

This separation of the lower and higher levels of hospital staff is accentuated by our unintentional finding of all the changes that were taking place, independently of the central initiatives. In this setting of constant change at local level, why would a merger of two health regions, at a very different organisational level, matter? For the individual respondent the local changes were probably "bigger" and more relevant than the overall merger.

5.4. Meeting the goals

With no new goals for the activity and with no new formulated mission for the trusts' CEOs, it is not surprising that economic performance and profile of patient treatment have developed similarly to other health regions. Furthermore, there are no signs of any drop in activity or economic performance either, nor of any negative development in the work environment. This is contrary to some international experiences [42,49].

The part of the strategy concerning research and education was the only one that expressed a specific situation from which to develop and to compare with other regions. These goals were not new, but were underpinned and made more demanding through the strategy process. During the period under study, this situation did actually move closer to the goals expressed.

6. Conclusions

There is a large literature on the problems that often follow mergers. This knowledge was available to the SEHR management, but we found no indication that it was discussed or used. A strategy should be more than a vision of good practice. According to Magretta, Porter claims that "... strategy requires a tailored value chain, and that is often forgotten" [50]. That was the case with the SEHR strategy. It did not describe either a starting or an end point. Instead of prioritising what to achieve and gather the organisation around the tasks, some formal changes in the responsibilities of the trusts were implemented, and the Oslo hospitals were given a single leader. "...management tools have taken the place of strategy" [51].

After studying the strategy process and its implementation in SEHR, we would sum up these essential points for a strategy to achieve changes:

- It must establish objective goals that cannot be met within existing modes of operation.
- It must describe how the new model will help to realise the goals expressed.
- There must be a significant willingness to prioritise and make trade-offs.
- The resources and time needed to achieve fundamental changes must not be underestimated.
- In order to reach out to all employees, the policies must be described in terms that are relevant to their daily activities.
- There must be strong positive support from the management.

Conflict of interest statement

There is no conflict of interest connected to this article.

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