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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.