The implementation of the Norwegian Coordination Reform

A single-case study of the negotiation process of a contract between municipalities and a hospital

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ABSTRACT

The Norwegian Coordination Reform was implemented on January 1st 2012 and it brought along changes for both the primary- and the specialised health care sector. The main changes resulted in a shift in the responsibility of which health care provider was to do which tasks, as well as how the financing of the costs for some treatments in the specialised health care sector would be arranged. In order to make this arrangement more clear for these two parties they were obliged by the government to make legally binding contracts to formalise e.g. how the tasks were to be divided between them and how the two health care sectors were to improve their cooperative patterns in order to ensure more coordinated health care services for the patients. This thesis looks into the negotiation process of coming to terms on these contracts by studying the case of one Norwegian Health Trust and the municipalities in this Health Trust’s catchment area.

The theoretical framework for the thesis consists of negotiation theory, with some sub-theories of structure, culture and power regarding negotiations. The thesis is empirically based and a single-case study, and there was conducted in-depth interviews with some of those who were directly involved in the process, from both the municipal side and from the hospital.

The outcome of the process was a success and there were detected three main success factors in the study;

- The importance of participation by the CAO’s in the process.
- Municipal alliance. 21 municipalities joined together is a much stronger unity than 21 municipalities negotiating for themselves.
- The hospital’s preparation. By recruiting staff with professional experience from the municipalities the hospital was much more prepared for what they could expect in the negotiation process than what the municipalities were.
There were also findings that indicated that there was a superficial disagreement among the parties that was based on their expectations towards each other due to previous experiences. I call the disagreement superficial because it did not seem like the disagreement was based on what they were negotiating over, since they were more coherent in their focus areas and their desired achievements than what they were aware of themselves.

Another interesting finding was that governmental disruption late in the process was not taken well by either of the parties. The Ministry of Health and Care Services tried to intervene in one of the elements negotiated over in the negotiation process. Both parties decided not to follow the Ministry and the parties seemed to have improved their cooperation on the basis of this decision.
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What may be found of errors in the thesis are non others than my own.

Oslo, May 2012
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<table>
<thead>
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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>HOD</td>
<td>The Ministry of Health and Care Services (in Norwegian; Helse og omsorgsdepartementet)</td>
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<td>KS</td>
<td>The Norwegian Association of Local and Regional Authorities (in Norwegian; Kommunesektorens organisasjon)</td>
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<td>HT</td>
<td>Health Trusts (in Norwegian; helseforetak)</td>
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<td>RHA</td>
<td>Regional Health Authorities (in Norwegian; regionale helseforetak)</td>
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<td>CAO</td>
<td>Chief Administrative Officer (in Norwegian; rådmann)</td>
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<td>NSD</td>
<td>Norwegian Social Science Data Service (in Norwegian; Norsk Samfunnsvitenskapelig Datatjeneste AS)</td>
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<tr>
<td>GP</td>
<td>General Practitioner (in Norwegian; fastlege)</td>
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<td>DRG</td>
<td>Diagnose Related Groups</td>
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<tr>
<td>ØKOKRIM</td>
<td>The Norwegian National Authority for Investigation and Prosecution of Economic and Environmental Crime (in Norwegian: Den sentrale enhet for etterforskning og påtale av økonomisk kriminalitet og miljøkriminalitet)</td>
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1. INTRODUCTION

January 1\textsuperscript{st} 2012 was the date when a substantial health care reform in the Norwegian health care politics, the Coordination Reform, was implemented. This reform contained changes that affected both the primary health care and the specialist health care, i.e. the health care provided by the municipalities and the health care provided by the state owned hospitals. The changes implemented by the reform were both of a financial and a legal nature, and it also caused some practical changes regarding the responsibility held by the health care workers towards their patients.

One of the aspects of the legal change was that the two parties of this process, i.e. the municipalities and the Health Trusts (e.g. hospitals), were obliged to create and sign legally binding contracts containing a minimum of elements set by the government. The elements varied from determining where specific tasks were to be executed and whether it was the municipalities or the state that had to pay for different health care services, to plans for emergent health care as well as research and education. It is the process of coming to terms on this contract that is the topic of this thesis, more precisely the negotiation process between the municipalities and the hospitals that occurred before the implementation of the reform January 1\textsuperscript{st} 2012. The theme for this thesis is an interesting case to study because it is the cooperation, coordination and relationship between the municipalities and the hospitals that will have the greatest impact on whether the reform eventually is a success or not.

The theoretical framework for this thesis is mainly about negotiations, which includes negotiations as a phenomenon as well as structural aspects, cultural aspects and power in negotiations. The study design for the case used in this thesis is a single case study with in-depth, semi-structured elite interviews. The data collection and analysis are mainly based on the informants’ personal stories.

The outcome of the negotiation process was that the contract was agreed upon and signed by both parties, even though there were some “bumps and bruises” along the way. The municipalities were able to join forces after a while and they were able to establish a group where they all participated, which also made it possible for all the 21 involved municipalities to speak with one voice rather than 21 voices. The level of
equality between the parties seemed to shift during the process from the municipalities feeling like an underdog to the hospital being almost set aside waiting for the municipalities to decide how the contract would end up. The informants for the case described in this thesis came from both sides of the negotiation, i.e. from both the hospital and the municipalities, and they all expressed that the process was needed in order to establish an even better coordination and cooperation between them, which they also succeeded in during the process.

1.1 Hypothesis and research question

As indicated above this thesis will be focussed on the process where a specific hospital and the municipalities in the catchment area of this hospital created a new contract, which was obligatory in the implementation phase of the Norwegian Coordination reform. The hypothesis of this thesis is inspired by the findings by Kalseth and Paulsen (2008) who did a study on a cooperation agreement, i.e. voluntary contracts, between hospitals and municipalities in 2007. What these researchers found was a tendency that municipalities felt that the hospitals were too much in the lead in the (similar) process and that the municipalities felt unequal to the hospitals in the process. I wanted to find out whether these tendencies still were a perception among the municipal actors in the process, and if so how that affected the process. I also wanted to explore the negotiation process as a whole in order to understand why the process ended up the way it did. Thus, my research question for the thesis is as follows:

“What can be seen as the key factors that enhanced success in the negotiation process between a hospital and the municipalities in the hospital’s catchment area in the south-east area of Norway?”

In order to answer the research question I will look into some sub-questions, as these will be helpful in understanding the negotiation process and thereby also detect which key factors that seems to have enhanced success in the outcome of the process. The sub-questions are the following;
• What are the formalities and background of the process?
• What was the starting point for the process?
• How did the process evolve?
• Were there any “wild cards” affecting the process?
• In what way did the process lead to an outcome that both parties could accept?

The research question and the sub-questions will be answered by analysing interviews conducted with some of the representatives who were directly active in the negotiation. It is the personal stories and opinions of those who were present and a part of the process that are of interest.

In the relevant case for this thesis there was also three districts of Oslo that negotiated with the hospital, but as the arrangement for these districts were quite different than for the municipalities, the districts of Oslo are left out of the investigations described in this thesis.

1.2 The Coordination Reform

The Coordination Reform was proposed by the former Norwegian Minister of the Ministry of Health and Care Services (HOD) Bjarne Håkon Hanssen, in June 2009. The reform was ratified in April 2010 by the Norwegian parliament, the Storting, and it was to be implemented the January 1st 2012. (The Storting, 2010) The reform was quite substantial as it induced changes for both the primary health care sector and for the specialised health care sector, with changes taking place legally, financially and organisationally. The reform aimed to solve three main challenges in the Norwegian public health sector, all of whom had been acknowledged within the sector for many years;

• That the patients’ need for coordinated services was not sufficiently met.
That there was not enough initiative for preventing and limiting disease in the health sector.

That there was a growing population which led to both a higher fraction of elderly people and a changed variation of illnesses in the population.

(The Ministry of Health and Care Services, 2009)

All of these challenges could, according to the reform, be met by improving the cooperative patterns and coordination between the health care workers in the primary health care services and in the hospitals. In the proposition of the reform there was described five means for these three challenges mentioned above. These means were to function as a regulatory framework as well as having partially structural character;

- A clearer patient role, i.e. creating good and cohesive patient pathways with one person as a contact point for all services, organised by the municipality.
- A new municipal role for the future, i.e. a more active role towards the municipalities’ inhabitants’ health state both practically and financially.
- Financial incentives, i.e. municipal co-payment for dischargeable patients.
- A more correct distribution of tasks between municipalities and hospitals, i.e. letting the specialised health care workers focus on specialised health care services.
- Facilitating more defined priorities, i.e. more focus on prioritising decisions on cohesion in patient pathways rather than on partial services.

(The Ministry of Health and Care Services, 2009)

The reason for implementing the reform, i.e. the facts used to justify the need to introduce a new reform, will not be described more thoroughly as I do not consider this as relevant to understand the background for the thesis’ case.

During the Ministry’s work in preparing the health care sector for the reform it was decided that municipalities and hospitals within the same health region had to engage in
contracts with each other. As these contracts turned out to be quite detailed and complex it was decided that parts of the contracts were to be settled and signed no later than January 31st 2012, while the remaining parts of the contract were to be settled and signed by July 1st 2012. Due to the complexity in the contracts HOD published a manual in October 2011 for the parties of the negotiations to use in their processes, in order to help them succeed with their final product. (The Ministry of Health and Care Services, 2011)

The idea of having contracts of this kind was not new. Already in 2007, the government and the municipalities’ interest and employer organisation KS decided on having so-called intentional contracts, i.e. voluntary contracts, between hospitals and the municipalities. (The Ministry of Health and Care Services, 2009) The intention of introducing such contracts was to improve the cooperative patterns between these two governmental levels in order to improve the care of patients.

1.3 The contracts

Having contracts within the health sector or having contracts between the primary health care sector and the specialised health care sector is not a new phenomenon. A study by Kjekshus and Bernstrøm (2010) showed that there has been an increase in the number of hospitals and municipalities who have engaged in contracts about transferring dischargeable patients to the primary health care from 58 per cent in 1999 to 85 per cent in 2009. There was a quite large leap from 58 per cent to 81 per cent between 1999 and 2001. (ibid.) As a consequence of this tendency it became necessary for the hospitals to hire personnel that were to have as a primary task to have contact with the municipalities to prepare them for patients who would be in need of health care provided by the primary health care services. In 1999, 35 per cent of the hospitals had such personnel, while in 2009 there was only 25 per cent of the hospital that had such personnel. (Kjekshus and Bernstrøm, 2010)

The contracts following the Coordination Reform were made obligatory for municipalities and hospitals to sign and they were quite comprehensive, and the content of the contracts reflected the content of the new law on health and care services, The Norwegian Health Service Act (Helse- og omsorgstjenesteloven), that took effect
January 1st 2012. What was rather special about these contracts was that they were obligatory and therefore deviated from a contractual freedom which is prevalent in Norwegian contract law. (The Ministry of Health and Care Services, 2011) In the contract manual published by HOD a section of this new law is elaborated, i.e. § 6 Cooperation between municipalities and Regional Health Authorities etc. A subsection of chapter six in the new law, § 6-2, dealing with the requirements for the contract’s content presents 11 elements that were to be agreed upon by the two parties, as a minimum. (ibid.) Of these 11 elements there are four that are of particular interest for this thesis, as they were what the municipalities and hospitals were to come to terms on by January 31st 2012 (the elements are numbered in the same order as done by the government);

1. agreement on what health and care tasks the different management levels (i.e. municipal or hospital) are given the responsibility for and a common perception of what measures the parties at any given time are to carry out,

3. guidelines for admission of patients to the hospital,

5. guidelines for coordination of dischargeable patients who presumably are in need of municipal services after the discharge from an institution,

11. joint emergency plans and plans for emergent medical treatment

(The Norwegian Health Service Act § 6-2 (Helse- og omsorgstjenesteloven))

The manual did not recommend any specific organisational way of solving the different challenges but stressed that the contracts should be consolidated on the highest relevant level in the organisations, as well as ensuring that the content of the contracts are revealed to those it may concern. HOD also stressed that the cooperation between the municipal sector and the HTs and RHAs was to be based on equality and mutual respect. (The Ministry of Health and Care Services, 2011)

Most Norwegian health regions did already have some experience with the intentional contracts from 2007 (Kalseth and Paulsen, 2008). These contracts were initiated by KS and HOD and the intention was to improve the cooperative patterns between municipalities and hospitals and by ensuring that the parties were to form a basis of the two parties as equals. (The Ministry of Health and Care Services, 2011) In 2007, as many as 82 per cent of the Norwegian hospitals had engaged in contracts with
municipalities regarding transferral of dischargeable patients to the primary health care services. (Kjekshus and Bernstrøm, 2010)

A study by Kalseth and Paulsen (2008), where they evaluated the process of creating the intentional contracts from 2007, they found evidence that many municipalities felt unequal to the hospitals due e.g. to the fact that most hospitals had a higher degree of professional actors in their staff than the municipalities did.

1.4 The two parties; municipalities and hospitals

The two parties in the process of interest for this thesis are municipalities and health trusts, in this case especially hospitals, both in a Norwegian context. As these two types of organisations are quite different an outline of how they work and operate is given below.

1.4.1 Municipalities

There were 429 municipalities in Norway by January 1st 2012 (The Ministry of Local and Regional Development, n.d.). The Norwegian system is organised in a way where the state has a responsibility for financing the municipal activity, while the municipal authorities have the responsibility for the accomplishment of the activity required. Because of the state’s financial responsibility, which induces an accountability for the municipal sector, the state supplies the municipal sector with regulations for their activities. The main activities the municipal sector has been required to produce are education, health and social services (primary health care, nursing homes, and general social services), technical services (water supply, renovation, municipal planning, and chimney sweep and fire brigade), as well as culture (church (including graveyards) and some voluntary cultural activities). (Hagen and Sørensen, 2006) As can be seen, the municipal focus is quite diverse.

The regulations supplied by the state are the state’s tools since they cannot instruct the municipalities. The regulations must therefore be determined through legislations, negotiations or budget resolutions, and will as a result often have restrictions on the
municipal prioritising and actions. Another and somewhat milder result of regulations are guidelines for how specific tasks should be executed. (Hagen and Sørensen, 2006)

The municipalities are run by elected local politicians, through a body called the municipal council. This body is elected for a four year period, and it is this body that has the formal decision-making authority. (Hagen and Sørensen, 2006) Municipalities do also have an administration to help prepare cases for the municipal council, and to execute the decisions made by the council. Each of these administrations is led by a chief administrative officer (CAO). Every task the municipal council delegates is formally delegated to the CAO, who in turn can delegate the tasks to his or her subordinates. (ibid.)

1.4.2 Hospitals

Norwegian hospitals are formally called Health Trusts, as a result of an ownership reform implemented in 2002, where the ownership of the hospital was transferred from the counties to the state level and the hospitals were organised like enterprises. (Stigen, 2005, p. 28) The governmental ownership is currently organised through four, previously five, RHAs which administrate the health trusts, i.e. hospitals, hospital pharmacies and some drug rehabilitation institutions (The Ministry of Health and Care Services, n.d.), in their district.

This shift in ownership of the hospitals implied that how the hospitals were managed would be discussed in the parliament, i.e. the Storting, and the Ministry rather than in the local societies, as a result of a blame game that had been going for years between the state, the counties and the hospitals concerning finances and the degree of control and/or autonomy of the hospitals. (Opedal, 2005, p. 88-89) The shift in ownership led the national government to take over the responsibility of the specialist health care. In this process the government established five RHA’s as administrative bodies to run several underlying bodies, the HT’s, that were to be responsible for providing health care services. Both HT’s and RHA’s are legally independent units. (The Ministry of Health and Care Services, 2006)
In Mintzberg’s typology over types of organisations, hospitals are a clear example of the professional bureaucracy, where the organisation highly values standardisation of tasks and knowledge and hires duly trained professionals, i.e. specialities, for the organisation’s operating core and then gives them considerable control over their own work. These types of organisations emphasises authority of a professional nature, i.e. the power of expertise. (Mintzberg, 1983) There is a great deal of decentralisation of power to the professionals in this type of organisation, on the expense of the top management. The top management serves as facilitators to the medical professionals. (ibid.)
2. THEORETICAL FRAMEWORK

2.1 Negotiations

Negotiation is, according to Mogens N. Pedersen (2007), a basic form of social interaction in both politics and the society as a whole. A negotiation is a social relation that consists of two or more parties, and we can distinguish between bilateral- and multilateral negotiations. (Pedersen, 2007) A premise for negotiations taking place between two parties with different interests are that the interests are not too conflicting as well as the necessity of the parties having some common interests that bring them together to find a common solution. (Jacobsen and Thorsvik, 2007, p. 298-299) In negotiations there can be some difficulties in distinguishing between the people in the negotiation and the case being negotiated over. There will be different interests following the case the parties are negotiating over and as all negotiations are characterised by interaction between people, who will bring emotions and perceptions, thus all negotiations will therefore contain both the case and the negotiators’ emotions. (ibid.)

We can distinguish between two types of negotiations; distributive and integrative. (Jacobsen and Thorsvik, 2007, p. 299) Distributive negotiations are about distributing a certain amount of resources and there is a win-lose situation where one party “wins” and the other(s) “lose”. This type of situation is often called a null-sum game. An integrative negotiation is a situation where it is possible to achieve a win-win situation, i.e. a situation where the parties can come better out of a situation by considering which interests they have in common, instead of solemnly acting out of own interest. (ibid.)

Negotiations as a phenomenon is a practical example within the theory called game theory, and this theory is about the interaction between rational parties, or actors, where the goal of the actors is to maximize their interest. (Hovi, 2008) Games can, according to this theory, be either static or dynamic. A static game is a situation where the actors’ or parties’ strategies are the same as their actions, and where the actors carry out their choice of action at the same time, leaving to chance of response to the other(s) action. A dynamic game on the other hand is a situation where there is a difference between the
actors’ actions and strategies, and where at least one of the actors can respond to whatever the other actor(s) do. (Hovi, 2008)

There are different approaches or strategies in a negotiation process. Burns, Bradley and Weiner (2012) describe three common strategies when the goal of the negotiation is to seek resolution; *compromising, competing* and *collaborating*. Compromising is a strategy where the parties divide their values and find a solution that satisfies both parties, leaving none of the parties as either winners or losers. Competing is a strategy where one of the parties has little concern for the other party and tries to get as many benefits for one-self out of the negotiation process as possible. Collaborating is rather the strategy where the parties have a high degree of concern for both the other party and for the outcome of the negotiation process, and this strategy has been shown to be most efficient in negotiations as this strategy invokes reciprocity between the parties. (Burns, Bradley and Weiner, 2012)

There are also strategies worth noting when studying a negotiation process concerning tactics in finding a good solution to the process. Examples of these are; *adding issues, fractional issues, and logrolling*. Adding issues is a quite simple tactic for negotiators as it simply involves adding one issue to the table at the time, giving both parties the opportunity to state whether the issue is important or not for them, which in turn can facilitate logrolling. This tactic can help the parties finding common grounds and it can also help the parties creating values. Fractional issues are a negotiating tactic where the actors will simply fraction a specific issue into separate, various components. This is a tactic used to finding better solutions by bringing smaller components to the table rather than whole issues at a time. Logrolling is a tactic used in negotiations that involves the actors trading off on issues that are of different value to each party. This is a four step procedure; step one being adding issues to the table, step two is to negotiate over these issues at the same time, step three is for the parties to discover that each party prefers one issue over the other, and step four is to negotiate a trade-off where each party receives each their preferred position on a specific case. (Burns, Bradley and Weiner, 2012)

There are also tactics the parties can use to influence the other party, such as *coming with a strong opening offer, forming coalitions*, and using “*Best Alternative to a
Negotiated Agreement” or the power of walk-away. (Burns, Bradley and Weiner, 2012) Coming with an opening offer could be beneficial for the party that proposes it, if they have objective data to support the offer, because of a psychological effect called anchoring bias. This bias, or at least the information that follows from the opening offer, tends to influence the other party to subsequently thinking especially if there is uncertainty in the thinking of the other party. The anchor then tends to become a key piece of information that frames the negotiation process and influences what the other party expects regarding the outcome of the process. The tactic of forming coalitions is used to strengthen the power, and further their interests for the negotiation, of the parties or actors in the negotiation process. Coalitions form when those parties that have compatible interests align themselves in order to negotiate with another party, and thereby increasing their power. “Best Alternative to a Negotiated Agreement”, often referred to as BATNA, is a tactic that only becomes relevant if the negotiation process fails, and the tactic then represents the best option when agreement cannot be reached, namely the power of walk-away. BATNAs are often used when one of the parties is dependent on the resources that one of the other parties obtain. When a party uses BATNA as a tactic, the power in the negotiation increases immediately and thereby it can influence the other party’s willingness to concede. (Burns, Bradley and Weiner, 2012)

2.1.1 Structural aspects in negotiations

Structure can be perceived as “building blocks” and in a negotiation situation there are both situational structure and the structure of the parties, in this case, municipalities and hospitals, that can be found and analysed. Hegdal describes that a situation’s structure can in a situation such as negotiations be characterised by defining the set of actors, with a defined structure of preferences over a defined set of subjects. (Hegdal, 1991, p. 21) If there is uncertainty and complexity in the negotiation process it will lead to a situation where alternatives to solutions must be developed through the process. In this case the outcome of the negotiation will be a function of the negotiation process, and the knowledge the actors may have to the alternatives to solutions may be limited in the beginning of the negotiations. (Hegdal, 1991, p. 18)
Structure of the organisations present in negotiation processes is also of interest. Organisational structure, which in organisational theory is often analysed in the instrumental perspective, is the formal components of an organisation often found in organisational charts, formal rules and norms, the presence or absence of positional hierarchy, etc. Purpose rationality of actions are viewed as essential in this theory, meaning that there is a logic of consequence of all actions executed. (Christensen et al., 2004; Jacobsen and Thorsvik, 2007)

Within the instrumental perspective there are two variants; the hierarchic variant and the negotiation variant. In the hierarchic variant the focus is on the managers control and analytic-rational calculation, while in the negotiation variant there is a focus on assertion of interests, negotiations and compromises between organisations and actors with partially conflicting interests and goals. The negotiation variant also emphasise the importance of how the change process is organised and whether it promotes or hinders assertion of interests and the use of resources. (Christensen et al., 2004)

By using these aspects in the analysis I expected to find that the difference in organisational structure between the two parties, i.e. the municipalities and the hospital, will have had some effect on the negotiation process. I also expected that the situational structure of the negotiation process had some effect on the outcome of the process.

### 2.1.2 Cultural aspects in negotiations

Culture is in the organisational theory referred to as the institutional perspective, and the perspective focusses on the informal values and norms in an organisation. These norms and values will grow and mature over time and will have a great impact on the daily life in organisations. (Christensen et al., 2004) A key concept in this perspective is sense of community, because culture is a social phenomenon and therefore only occurs in social communities. (Jacobsen and Thorsvik, 2007, p. 117) The organisational culture is influenced by the organisation’s structure, and as culture develops through interaction within a specific group there can in large organisations be many subcultures present due to departmentalisation. (ibid.)
Cultural, or institutional, aspects of negotiations can emerge by the people who hold the position as representatives in the negotiation situation and the characteristics of the representatives which again will influence how they negotiate. (Hegdal, 1991, p. 22) By this it is meant that the people directly involved in any negotiation process will influence its outcome, and that this is a result of what kind of mindset the people involved have. It is the people present who will lay the premises of the process, whether it is positive or negative. When and where the negotiations are being held is also of interest in this perspective. (Hegdal, 1991, p. 24) This is both a cultural and a symbolic aspect, of either being at known territory or not. It is also an aspect of interest how the physical settings are for the negotiation, if anything in particular can be noted.

I expected to find that culture did play a role in the negotiation process discussed in this thesis, such as that the people involved in the process had impact on how the outcome turned out and that the difference in culture in the hospital and the municipalities may have caused some difficulties along the process.

### 2.1.3 Power in negotiations

Power is defined as the control one group has over another group’s behaviour (Hickson et al., 1971 cited in Burns, Bradley and Weiner, 2012, p. 186), and central in this power is an idea of influence (Dahl, 1957 cited in Burns, Bradley and Weiner, 2012, p. 186). Power can be derived in different manners, either from structural sources, from cultural sources, or from knowledge-based sources. (Burns, Bradley and Weiner, 2012) Structural sources imply that power comes from e.g. written policies and instructions, from positional hierarchy, from legal documents, or from budgets. Cultural sources of power can be hard to identify but this type of power comes from an implicit understanding and appreciation of the cultural perception of how things are done in an organisation. Power from a knowledge-based source comes from the control one group has over the expertise which is needed to make key decisions and to organise production of whatever good is produced. (ibid.) Note that none of these three sources of power work alone, they rather interact with each other.

Regarding the power aspect in the negotiation process I expected to find that the actors had certain expectations of the other party regarding power and strength, such as
Kalseth and Paulsen (2008) showed in their study that some municipalities had a perception of the hospital as a stronger actor in the negotiation process in 2007, and that there will be an inequality in this strength relationship. Furthermore, I also expected to find that if there is a difference in power it will also have an effect on the process.
3. RESEARCH METHODOLOGY

3.1 Choice of study case and methodological approach

The purpose of this project was to gain insight of the interaction between two of the main actors in the practical Norwegian health care politics, namely the municipalities and the hospitals. I was made aware that these two actors were in the process of negotiating over the contracts that were made mandatory in the implementation phase of the Coordination Reform, and I wanted to look more into this process. In order to gain this insight it was early in the project decided that it would be appropriate to focus on a single case, and go in depth of this case, to understand the mechanisms present in such a situation. This implied that the study would be qualitative. The study was also retrospective as the case studied had already happened.

Case studies are a very useful study design when the purpose is to explore an area where little is known, or if the researcher is trying to obtain a holistic understanding of a situation or phenomenon. (Kumar, 2011, p. 126-127) This type of study design is of immense relevance when the focus of a study is to gain understanding and to extensively explore e.g. a phenomenon or situation, rather than to confirm or quantify. (ibid.) The design provides an overview and in-depth understanding of the specific case but the study’s conclusion can only be generalised to similar cases. (ibid.)

In order to obtain the data necessary for the study’s objective I also made the decision that I wanted to focus on the personal stories of some of the participants in this study case. I considered the best way of getting hold of these stories was to use a method of data collection referred to as “oral history.” (Kumar, 2011, p. 127) Kumar describes this method as a process of obtaining, recording, presenting and interpreting current or historical information based on the personal opinions or experiences of some of those who belong to the unit of interest for the research. (ibid.) The process of collecting these oral stories in my study would be done by conducting interviews with some key-informants. The interviews would be in-depth and semi-structured. The reason for choosing semi-structured interviews was that I wanted the informants to speak freely but within the topic for the thesis, so I had therefore prepared some questions that I
could use to direct the informants into the negotiation process if they were to wander off in their narratives. These questions were very helpful to utilise during the interviews.

Based on the typology Kumar (2011) uses, the study can be categorised as descriptive as the attempt of the project was to systematically describe a situation rather than examining relationships or associations. Descriptive studies will provide information about e.g. attitudes towards an issue. (Kumar, 2011, p. 10) The study can also be categorised as an exploratory study. This implies that the objective of the study is to explore an area that is little known. (ibid.) The process that is of interest for this thesis is in some ways new in the study of Norwegian health care politics as the contracts negotiated over by the municipalities and the hospitals now were made mandatory. There have been some voluntary contracts between these two parties for some years already, but now that the contracts are made mandatory and more detailed and therefore there were some new aspects that made this negotiation process different from the previous processes.

The reason for choosing the health region that is studied in this thesis was mainly coincidental but to some extent out of convenience. It was coincidental as I also could have chosen another health region on the other side of Oslo, and it was convenient as the health region is close to Oslo and it would therefore be easy for me to travel to the informants on short notice in order to conduct the interviews. As I come from one of the municipalities in the health region that I chose it was particularly interesting to study the process in this region, however I was very aware of the risk of research bias that could occur because of this.

The study-case consists of a large Norwegian hospital and the municipalities that are in this hospital’s catchment area. In the same catchment area there are also three districts of Oslo, but I chose to exclude these from the sample size because these districts did not follow exactly the same process as the municipalities. The districts of Oslo have other arrangements because they also have arrangements with the municipality of Oslo. By excluding the Oslo districts the results of the study would be more applicable to similar cases in other parts of Norway, due to the fact that all the other Health Trusts in Norway, besides Oslo and the Health Trust studied in this project, have a municipality-hospital relationship.
3.2 Sampling method, recruitment and the informants

As it was quite hard to find any written sources, e.g. at the Internet, about who was present in the negotiation process it soon became clear that the method of sampling would be snowball sampling. By following this approach each informant was asked at the end of each interview who they would recommend as informants in the project, preferably someone who had an active or otherwise important role in the process.

Snowball sampling is a non-probability sampling design where the selection of the sample happens through the use of networks. The researcher begins the sampling process by selecting a few individuals to interview, and after the required information is collected from them they will be asked to identify other people who in turn will be a part of the sample. This process will continue until the amount of information reaches a saturation point. This method of selecting is good in studying e.g. decision making. A disadvantage with this process is that the choice of the final sample is dependent on the choice of the first individuals. (Kumar, 2011, p. 208)

In order to narrow the sample size it was early in the process decided that the informants of interest should have had an active participating role in the process. This meant that I would not interview representatives from those municipalities who were in the same health region but not present in the negotiation, nor would I interview representatives from governmental organisations or interest organisations, such as HOD or KS.

The first informant was selected based on recommendations from some people whom I had spoken to when I prepared for the data collection. The name of this informant was mentioned by several people who had some knowledge about the process in this health region, and when I checked who this person was it was also discovered that the occupational title of this person made it natural to begin by interviewing this person.

The informants were recruited by e-mail correspondence. They received an information letter about the study with a consent form for participating in the study attached as it was necessary to have the informants to sign this form in advance of the interviews. Those informants who were recruited on the basis of recommendation from other informants, i.e. based on the snowball sampling method, were told this but they were
not told by whom they had been recommended. It was necessary to send follow-up e-mails to remind the potential informants about the invitation to participate in the interviews. Six key-informants accepted the invitation while two key-informants declined. All the interviews were conducted after the contract had been signed by both parties, more precisely the interviews were conducted during February and March of 2012. A translated version of the information letter is attached as an appendix to this thesis.

The informants were representatives from the hospital, one representative from the presidency and one from the Department of Coordination. From the municipalities, two CAO’s and heads of municipal affairs were interviewed. These informants had been participants in either one or both phases of the negotiation process. Because of confidentiality considerations and to protect my informants, and also to fulfil a regulation made by NSD for qualitative research where there is a risk that the informants can be recognised, the informants will not be described in any more detail.

3.3 Data collection; the interview process

The interviews were semi-structured and in-depth and were all documented by notes taken during the interviews as well as using a tape-recorder. The content recorded was later transcribed. Three of the informants were interviewed alone while the remaining three were interviewed together as a focus group. The reason for conducting one of the interviews with a focus group was mainly out of efficiency considerations since these three informants were from the same organisational unit, i.e. a municipality.

The interviews were, as previously described, semi-structured. This means that I had prepared an interview guide that was designed so that the informants could speak fairly open about the topic. The main objective of the interviews was to have the informants tell their own story and perception of the process. As the study was partially explorative it was necessary to modify the interview guide after the first interview as that was the first time that I could judge how the interview had progressed. The modification of the interview guide was mainly to focus the questions in order to make sure the conversation in the interviews was kept within the relevant topic. A translated version of the interview guide is attached as an appendix to this thesis.
The interviews were conducted in the working environment of the informants, mainly in their offices. This was something I encouraged as I wanted the informants to feel relaxed during the interviews as well as I understood that the informants had tight schedules and that it would therefore be much easier to find time for the interviews if I travelled to them rather than the other way around. Each interview lasted for about one hour.

The transcription of the interviews was done very thoroughly. There was done a considerable effort in eliminating errors in this process. As I made some notes during the interviews it was easier for me to recall which parts of the interviews that were of particular interest while conducting the interviews. At a few incidents there were some problems in understanding what was being said in the recording of the interviews, either in the case of focus groups were the informants spoke at the same time and interrupted each other, or because the informants were speaking unclearly while telling their stories. This was an issue I was very much aware of and spent a significant amount of time trying to rule out errors.

3.4 Ethical guidelines and considerations

Ethical considerations are very important to ensure in the field of research and it was something I strived to follow throughout the process of writing this thesis. The study was reported to, and approved by, NSD.

3.4.1 Informed consent

Informed consent implies that the informants have expressed their willingness to participate in a study on the basis of being adequately and accurately aware of the purpose of the study and why they are asked to participate in the study, and how this may affect the informant. (Kumar, 2011, p. 244) The consent must be made voluntarily and without any use of pressure from the researcher towards the informant. (ibid.)

As mentioned previously in the thesis the informants were sent an information letter and a form of consent to sign in advance of the interviews. The letter of information was written in order to make the informants aware of what the intention of the study was,
who the researcher was, how the data material would be treated after the study was over, that the information they would give during the interviews would be treated confidentially, and that they could withdraw their consent at any time. This was to ensure that the ethical principle of informed consent was fulfilled, and it was also an obligation for me to ensure that this was done in order to get the approval from NSD to conduct the study. All but one of the informants interviewed in this study signed their consent form in advance of the interviews, the remaining informant signed it after the interviews but this late signature was approved and accepted by both me as a researcher and by the informant. One of the elements in the letter was information concerning the use of quotes from the interviews in the thesis, and it stated that the quotes that are cited in the thesis will be checked with the informant who stated the quote so that he or she can approve it. All quotes used in the thesis have been checked with the informants.

### 3.4.2 Confidentiality

Confidentiality implies that the information that has been collected cannot be used for other purposes than what the intention was during the data collection. It also implies that after the data has been collected there should not be possible to identify the sources, i.e. that the sources are granted anonymity. (Kumar, 2011, p. 246)

Confidentiality of the informants and the information they gave during the interviews has been maintained sufficiently. None other than me have read the transcribed versions of the interviews or listened to the recordings of the interviews. The names of the informants have not been revealed to those it did not concern. One of the informants asked in advance of the interview whom else had been interviewed by me for this project, and I felt that it was necessary to be open about this. The informant that requested this information did not seem surprised, so I cannot see that this may have caused any bias for the thesis. None of the other informants requested any information of who the other informants were and this information was therefore not given by me to any of the informants. Neither did I share any sensitive information or any of the perceptions or thoughts that the informants shared during the interviews, this because I both wished to respect the confidentiality of the informants as well as not to affect the answers the informants were providing.
3.4.3 Avoiding bias

Kumar (2011, p. 246) describes bias as a deliberate attempt to highlight or conceal something that has been found in the research process, or to deliberately use a method or procedure that the researcher knows is not appropriate, in order to provide information that the researcher is looking for because the researcher has a vested interest in it. Bias is not the same as subjectivity, as subjectivity is an integral part of the researcher’s way of thinking and which is conditioned by e.g. educational background, research discipline, experience, philosophical perspective, etc. Subjectivity is therefore not deliberate but rather something that will influence how the researcher understands or interprets the information obtained. (ibid.) It is bias, not subjectivity, that is unethical. (ibid.)

I have been very focussed on the risk of introducing bias in my study, and I was therefore giving a lot of thought to the research methodology in order to find an appropriate method for the study’s purpose. I have also paid a lot of attention to the way the results are presented in order to present them as objective as possible. Presenting the results objectively was not a real challenge as the informants mainly had the same story to tell, but rather with some variations of their personal experience and reflections of the process. As I also conducted this study independently there were no organisations or other actors that could have influenced me in adjusting the obtained information in any way.

3.5 Validity and reliability

3.5.1 Validity

Validity in research refers to whether the researcher has measured what he or she sets out to measure. (Kumar, 2011, p. 178-179) In social science there are two approaches that establish the validity of a research instrument; the instrument is either based upon logic that underpins the construction of the research tool, or there is statistical evidence that is gathered by the use of information generated through the use of the instrument. The statistical procedure provides evidence by calculating the coefficient of correlations between the questions and the outcome of the variables, while the establishment of validity through logic implies a justification of each question in relation to the
objectives of the study. (ibid.) Validity is hard to establish in qualitative research where the researcher is exploring feelings, experiences, motivations, perceptions and stories. Because of this difficulty it is necessary to ask several questions in order to cover different aspects of the concept that is studied, and it is also important to demonstrate that the questions asked actually are measuring what they intend to measure. (ibid.)

Validity can be divided into internal and external validity, where the internal validity is described as the degree of credibility in the study, while the external validity is described as transferability of the study’s results (Kumar, 2011, p. 184-185), which can be understood as generalisation of the results and conclusions from a study, preferably to similar settings. (ibid.)

As I see it the study has internal validity since the best way of understanding what the success factors of the negotiation process were is to speak to those who were present in the process. The internal validity could not have been better by interviewing other parties, or by solemnly reading the minutes from the meetings. Thus, if I had been able to observe the meetings I could have been able to obtain even more information. This could also be the case if I could have arranged a focus group session with all the informants present. The reason for not using these two approaches was that the negotiation meetings were over by the time the data collection took place, and I chose not to conduct a focus group with all the informants at the same time as a result of it being too time consuming to contact all the informants and schedule a new interview session. I had experienced during the initial recruitment phase that it took more time than estimated to get responses from several of the informants and where there was a need to send follow-up invitations. As the information collected during the interviews was coherent I viewed the data material to be sufficient to conduct the analysis and to write the thesis.

Regarding the external validity the findings in this study will mainly be transferable to cases similar to the one studied. As the sample size of the case studied and evaluated in the thesis was determined using a non-probabilistic method, i.e. not representative for the population, it is hard to generalise my findings for e.g. all negotiations in Norway. It was never an intention for me to be able to generalise my findings in such a scale, I rather wanted to find some results that could be transferred to the many similar cases
with similar characteristics, and which are negotiating on the same contract elements as the parties in my thesis. The findings in my study can to some extent be transferred to similar cases in order to understand some mechanisms that may enhance success of a negotiation process, such as how the parties prepared for the process and how they positioned themselves in the process while it was on-going.

### 3.5.2 Reliability

Reliability refers to the ability the research instrument has to provide similar results when it is used repeatedly and under similar conditions. (Kumar, 2011, p. 181) If the research instrument is reliable it indicates stability, accuracy and predictability. (ibid.) In social sciences it is very hard to have perfect reliability because it is impossible to control all the factors that can affect the degree of reliability. Some of the factors that can affect the reliability of a research instrument are:

- **The wording of the questions;** if some words are ambiguous in either questions or statements the respondents, e.g. the interviewees, may interpret the question differently which may result in different responses.

- **The mood of either the researcher or the informant;** changes in the mood and motivation of both the interviewer and the interviewees can affect the responses given by the respondents, and thereby affecting the reliability on the research instrument.

- **The physical setting of an interview;** in an interview setting a change in the physical setting can affect the reliability of the research instrument, if there are repeat interviews.

- **The nature of interaction between the researcher and the informant in an interview setting;** the interaction between the researcher and the respondent can affect the responses given significantly.

(Kumar, 2011, p. 182)

All of these potential influential factors were something that I did my best to be conscious of. In both the recruitment phase and during the interviews I made an effort in
using a terminology that was both specific and what I considered to be of common knowledge. The questions that were asked during the interviews were mainly open-ended as I wanted the informants to tell their side of the story, and some of the questions were more closed-ended when there were some aspects or elements where I needed to understand, e.g. where the meetings were held. The physical setting during the interviews may have influenced the reliability, but hopefully in a positive way, as the interviews were solemnly conducted in the informants working environment. This was both out of convenience for the informants as it made it easier for them to schedule a meeting with me during their working hours, and it was something I hoped would make the informants feel relaxed so that the conversation with me would go smoothly. Regarding the mood and motivation of both me as a researcher and the informants, as well as the nature of interaction was also something I was aware of. As I could only be in control of my own mood I did my best in making a good first impression in regards of being calm, pleasant and in focus during the interviews. The informants seemed to be in a good mood during the interviews as they all expressed how exciting and important the process had been, and there was some jokes and funny comments during the interviews. There was only during the interview with one of the informants that I sensed a slight reservation in the answers that were given, but the answers given by this informant were still compatible to the answers given by the other informants.

### 3.6 Limitations of the study

This study has some limitations that should be made clear in order to understand in what way the analysis and conclusion can be of interest to the societal debate regarding the actors of the Norwegian health care sector and the premises for the coordination of patients and health care services in the Coordination Reform.

Some limitations of the study are results of the theoretical framework in the thesis, as I probably could have taken the theory even further into the core of negotiation processes. I had to limit the scope of the theory in order to stick to my research question as well as the limitations that results from the formalities of the thesis, e.g. number of pages. I see that I could have taken the discussion regarding power in negotiations further, but as I was searching for key factors that enhanced a successful outcome of the process, it did not imply that power was something to study more detailed.
One limitation is that nobody from the municipalities that were not present during the negotiation process was interviewed. This means that I cannot say anything about how the municipal cooperation of all the municipalities worked in the case studied in this thesis. If most negotiation processes resembles the process studied in this thesis, it would mean that most municipalities actually did not participate actively in the negotiation process, and the discussion can therefore be limited as I cannot say how the non-participative municipalities viewed the process and the outcome of the negotiation. By following through on this decision it was possible for me to say something specific about how the negotiation process actually progressed, as I solemnly focussed on those who were actively participating rather than discussing how those who had delegated the opportunity of negotiating to other municipalities experienced the process. This was a well considered choice of limitation.

It is also a limitation of the study that I have mainly evaluated the actual process of negotiation, but not having a focus on how the actors negotiated over specific elements of the contract. I can therefore not come with very specific statements on what was seen as difficult or easy elements to negotiate over, if any such elements were present. In the presentation of the results and in the analysis chapter there is mainly focus on one element that was mentioned specifically by all the informants, and that was the matter of dischargeable patients who had to be transferred to the primary health care services. Included in the discussion are issues such as who were to pay for patients who has not been transferred after being declared for discharge as well as how the communication between the hospital and the municipalities should be in order to make these transferrals run smoothly. The reason for this limitation being made was a consideration that it would be more interesting to find the more basic key factors that can enhance a successful outcome of a negotiation process rather than going deeper in the case to find potential key factors for each element in the final contract. By making this decision it was possible for me to stay with my research question rather than wandering off which would have made my thesis less precise and to the point.
4. RESULTS; THE HISTORY OF THE NEGOTIATION PROCESS

This chapter will begin by a description of the formalities around the contract the municipalities and the hospital were to negotiate over. There will also be a brief description of how the arrangements were before the negotiation process commenced, then the process itself will be described. The information that concerns the previous arrangements and the negotiation process comes from the informants of the study.

4.1 The formalities of the new contract

The parties of the negotiation process, i.e. the hospital and the 21 municipalities in the hospital’s catchment area, were to negotiate over four subjects which they were to come to terms on in order to create a contract and sign it by January 31st 2012. These four elements, out of totally 11, which were described quite specifically by the government through both the wording of the Norwegian Health Service Act and the manual for the contract formulation written by the Ministry of Health and Care Services, were as follows (the elements are numbered in the same order as done by the government):

(1) Agreement on what health and care tasks the different management levels (i.e. municipal or hospital) are given the responsibility for and a common perception of what measures the parties at any given time are to carry out.

(3) Guidelines for admission of patients to the hospital.

(5) Guidelines for coordination of dischargeable patients who presumably are in need of municipal services after the discharge from an institution.


(The Norwegian Health Service Act § 6-2 (Helse- og omsorgstjenesteloven))

The manual that accompanied the Act said the following about these four paragraphs; Regarding the first paragraph there were limitations saying that the parties could not agree on other distributions of responsibility than what the law states, and they could not take over the formal responsibility for some of the tasks. The parties could on the other hand carry out some tasks on behalf of the other, but only if the overall responsibility was left unchanged.
For the third paragraph it was stated in the manual that the health services were to be provided on the lowest efficient care level, which in Norwegian health care is called the LEON-principle (in Norwegian; laveste effektive omsorgsnivå). This meant that if the health care services could be provided by the GPs in the municipalities the patient should not be admitted to any hospital, and as soon as an admitted patient is no longer in need of specialised health care services the patient should be returned to the primary health care services. The manual expressed that the contract should clearly state how the contact between the primary health care services and the specialised health care services should be like, and that there should be systems for specifying whether the patients are in need of elective or emergent help, as well as systems for patient transport, and for readmission. It was also expressed that there should be a practice consultant arrangement between the parties so that they could learn more of each other.

The fifth paragraph regulated the arrangements for municipal financing of dischargeable patients, as well as the municipal obligation of finding vacant places in institutions within the primary health care services for those patients ready for discharge from specialised health care institutions and who are in need of more treatment, e.g. rehabilitation. The parties were obliged to agree on specific reporting systems between the municipalities and the hospitals regarding discharge of patients, and to agree on the criteria that were needed to be fulfilled in order to discharge patients. They were also to agree on transferring information to both GPs, municipal health care institutions and relatives of the patients when a patient was transferred to primary health care institutions for further treatment, and how the parties were to assess the need of ordering supporting materials for the patients. This paragraph is not applicable for patients within the mental health care or patients with alcohol or drug problems.

The eleventh paragraph which dealt with cooperation regarding reunited emergency plans is elaborated in the manual as an obligation for the parties to agree on elements such as risk and vulnerability analyses as a basis for the plans, planning and execution of drills, training and competence development, assuring supplies of pharmaceuticals, materials and medical supplies, and finding solutions of concrete challenges regarding emergency plans. (The Ministry of Health and Care Services, 2011) The manual also came with suggestions of how the contract could be worded.
The informants explained how the negotiation process had two phases, where the first was led by the hospital. This negotiation had representatives from both sides, and the informants from the hospital referred to this group as a joint group consisting of representatives from both the hospital and the municipalities, that worked as an editorial group. In the other phase the municipalities took the lead and did not include the hospital in the process of making a new contract. The informants referred to this group as an editorial group. The representatives who were present at the negotiations were mainly heads of municipal affairs, from the municipal sector, and representatives from the Department of Coordination, as well as from the presidency of the hospital. In the second phase of the process the municipal CAO’s were a lot more active than they were in the first phase, and the municipalities also made use of each others professionals such as legal advisors and –practitioners, etc. The heads of municipal affairs were present all through the process.

4.2 Context; the background of the process

In the case of interest for this thesis there are two parties; a hospital and the municipalities in the hospital’s catchment area. The hospital, i.e. the health trust, is quite large and is located in the area of the Regional Health Authority in the South-East region of Norway, RHA South-East. The hospital was recently modernised and opened new locations in October 2008, making the hospital one of the most modern in Norway (NRK, 06.11.2008) and it was given a lot of attention in the media because of this. In 2011 the hospital had a patient population in somatic health care consisting of about 208,000 outpatient consultations/treatments, the patients had about 53,000 days of length of hospital stay, as well as about 41,000 in-hospital stays. (Akershus University Hospital, n.d. A) The hospital had, in the same year, 8,346 employees (ibid.) divided on 13 facilities. (Akershus University Hospital, n.d. B) Hence the hospital is quite large in volume. Still the hospital has struggled for years with long waiting lists for their patients. This problem has also led to a problem with patients being placed in the corridors of the hospital, for which they have gotten a lot of negative publicity and attention from both the media and from the government. (The Storting, 2011; NRK, 28.03.2011)
The municipalities in the hospital’s catchment area now consist of three municipal regions that have a tradition of more or less cooperating on other fields or sectors, within their own region. The projects these regional groups cooperated on differed both in scope and in how organised the projects were. Only one of the regions had projects going concerning health care politics and health care services, while the others seemed to focus more on other political challenges such as environment, education and policy towards industry and business.

Up until the implementation of the Coordination Reform there was a provision of the previous act regarding dischargeable patients that stated that patients who were ready for discharge from a hospital had to be taken over by their municipalities within 10 days, if the municipalities and hospitals had not agreed on other terms. (Forskrift om utskrivningsklare pasienter) The provisions of the new act stated that patients ready for discharge who are in need of more health care services, that can be provided by the municipal health care service, must be taken over by their municipality immediately after being declared dischargeable. (Forskrift om medfinansiering av spesialisthelsetjenesten) If the municipality is not able to find a vacant place for the patient in a health care institution in their municipality, leaving the patient in the hospital to wait, the municipality must pay NOK 4.000 per day to the HT in order to cover the costs of the patient’s stay. The municipalities will also be responsible for paying 20 per cent of their inhabitants medical treatment in hospitals based on the DRG-rates for each treatment, but only for publicly provided health care services, except treatment in psychiatric wards, treatment for addicts in the specialised health care sector, outpatient laboratory and diagnostic imaging services, treatment provided by private health care contract specialists, as well as patients staying in private rehabilitation institutions. Some medical treatments are left out of the municipal medical co-financing. (Forskrift om medfinansiering av spesialisthelsetjenesten) These treatments either require hospitalisation or outpatient consultations and they relate to these four following medical categories; surgical treatment, labour, treatment for infants, and treatment with use of some specific drugs. (ibid.) There are set limits to the amount of co-financing that will be claimed by the municipalities; the municipalities will have to pay 20 per cent of the price of one DRG-point, and the co-financing charge will not exceed the price of 20 per cent of up to four DRG-points for one single patient stay. (ibid.)
In order to secure that the municipalities are able to prepare for the rehabilitation of a patient which is an inhabitant of theirs, the hospitals are required to report to the municipality about the patient’s status, expected progress, and estimated discharge date, within 24 hours of the admission of the patient. (ibid.)

4.2.1 The former local arrangements for the two parties

When the voluntary contract was agreed upon in 2007, there was only two of the municipal regions that were a part of the hospitals catchment area at the time. The voluntary contract is described in general terms in chapter 1.2. The voluntary contract worked fine between the parties, but there was no real legal or financial consequences for following the contract or not and the contract was therefore more of an instrument to help the parties improving their cooperative patterns. The parties had also, since about the mid-1990s, made other arrangements concerning the 10 days dead-line for taking responsibility for dischargeable patients as was required in the previous regulation regarding dischargeable patients, but these arrangements were not the same for all the municipalities in the hospital’s catchment area at the time. Some municipal informants for this thesis stated that this arrangement was more profitable for the hospital than for the municipalities.

In 2009 the hospital was informed by their owner, RHA South-East, that there would be a change in the catchment area of the hospital with an expansion consisting of a third municipal region as well as three regions of Oslo, due to a structural process in the health sector in Oslo in the same time period. The expansion became effective in 2011. As a result of this structural change the hospital was requested by RHA South-East in the fall of 2009 to begin the process of renewing the contracts with the municipalities (and the three districts of Oslo) in their catchment area. This was not a problem as the hospital and the municipalities had already agreed upon revising the contracts from 2007. The hospital was given end of 2010 as a dead-line to complete this process, and a group of representatives from the hospital and the municipalities got started. This process was led by the hospital and is a part of the first phase of the process, as mentioned above.
In order to prepare for the upcoming process the hospital established a new department solemnly dedicated to improve coordination and cooperation towards the municipalities. The department originated in 2004 and it was separated as an own department in the spring of 2008. The hospital recruited staff for this department from the municipal sector and counties, because the hospital managers acknowledged that they did not know enough about the municipal health care sector and the easiest way to solve this problem was to obtain that kind of competence by employing professionals who previously had worked in the municipal sector. This department was placed high up in the hospital system and was to report directly to the top management, more specifically to the vice president of the hospital.

In June of 2009 the Ministry of Health and Care Services presented the Coordination Reform. It became clear at an early stage that there would be mandatory and statutory contracts between the municipalities and hospitals, but this did not seem to affect the process that had already begun by the hospital led group.

### 4.3 The process of creating the contract begins

Representatives from the hospital began the process of making the new contract in 2009 and took the lead, as mentioned above, and they invited the municipalities to join the process. The hospital also included representatives from the employees and from the patients organisation. These representatives, about 30 from the municipalities and some from the hospital, worked together in an editorial committee.

The representatives from the municipalities were mainly heads of municipal affairs, but at this stage of the process there was a problem for the municipal representatives that they did not communicate with each other between the meetings. Representatives from both sides saw that the consequence of the municipal representatives not communicating properly was that they missed out on the opportunity to gather their forces and find an outcome of the process that suited them. There was also a problem that the representatives did have a very varying consolidation from their administrative managers. The CAO’s admitted that they did not see the invitation from the hospital as important enough for them to participate or something they needed to deal with and the CAO’s therefore delegated the responsibility to their health care professionals, mainly
heads of municipal affairs, to come to terms with the hospital on a contract. The
hospital’s representatives stated that they saw that this was difficult for the
municipalities and they witnessed how the municipalities’ representatives tried to
inform their superiors, i.e. the CAO’s, about the impacts the reform would have on the
municipalities, but without any success.

The meetings were held in the hospital facilities and in the autumn of 2010 the editorial
committee had written a contractual proposition that was sent out for hearing to the
municipalities in the catchment area.

In about the same time period as the proposition was sent out for hearing there was an
awakening in the municipal sector regarding the magnitude of the reform and the impact
the reform would have on the municipalities financially, legally and practically. This
was partially because KS got involved in the process on a national level. The result was
that the CAO’s in the municipalities got involved and decided to put a full stop in the
process in order for them to acquaint themselves with the content of the reform and the
proposed contract. The CAO’s in one of the three regions then decided to reject the
proposition and to take over the process themselves to create a new contract – without
the hospital’s participation. This left the two other municipal regions with the choice of
either following the municipal group that left the process or to continue with the
proposed contract from the hospital led group. They chose the first option. The
informants from the hospital stated that this was not an ideal solution for their part, but
that they went along with this because they hoped that this would make the
municipalities more actively involved in the process. Along with this decision there also
came an apology from the municipalities, to the hospital, that they had not taken the
situation seriously. The municipalities left the hospital waiting for about six months
while they were working on the new proposition. This was in the spring of 2011.

4.4 The municipalities take the lead

For the one municipal region that chose to step out of the process initially it was
necessary to take a step back and establish a common ground of trust, within their group
of municipalities, due to a quite recent event. A few years earlier there had been a
scandal in this region in an inter-municipal cooperation in a waterworks plant where the
president and a few other people of this company had been investigated and charged by ØKOKRIM for gross economical corruption and misappropriation, which the president and some others who also had been investigated was later imprisoned for. Even though those who were imprisoned were the ones to blame, this case also had negative consequences for some of the municipalities’ mayors, as at least one of them was dismissed from the position as a result of being bribed by the waterworks’ president. (ØKOKRIM, 2009)

One of the municipal informants stated that this incident resulted in so much friction and insecurity within the municipal region affected which again influenced the trust between these municipalities, that they needed to ensure that they had enough trust in their own region before they could negotiate with the hospital as a joint group.

One of the CAO’s in the region that had been directly affected by the waterworks scandal suggested in 2010 that the municipalities, preferably all the municipalities that were in the catchment area of the hospital, should begin a cooperation on the health area. In March of 2011 there was a meeting with all the CAO’s in the health region, i.e. the three municipal regions, and this meeting was the start of the cooperation between all of the municipalities. After this meeting there was established a group of six CAO’s, two from each of the three municipal regions, that would turn out to be a very important contribution for the negotiation process. The informants referred to this group of CAO’s as “the gang of six.” The CAO’s appointed some representatives from their municipalities’ health care services to participate in making the contract. They also appointed some of their legal advisors and other professionals who were to work as a group of advisors in order to assure that the municipal representatives followed the legislation, as well as financial principles.

The municipal editorial committee agreed that they wanted to ensure that the hospital could not declare patients ready for discharge after office hours on Fridays nor through the weekend, as this would be hard for the municipalities to handle. They decided to set a dead-line for the hospital to contact the municipalities concerning dischargeable patients to three o’clock in the afternoon on Fridays, and if the hospital did not stick to this dead-line the municipalities would not pay for the patients stay during the weekend. They also saw that it would be difficult for them to ensure patient transport in case the
patients would be in need of escort. Otherwise the municipalities mostly followed the initial contract proposal as well as the suggested wording from the manual written by HOD.

Even though the municipal actors in this second phase of the process did not actively include participation of the hospital, they still had some contact. The CAO “gang of six” regularly contacted the hospital to inform them of the progress of the process and they checked “the terrain” for some parts of the contract in order for the hospital to know what they were to sign shortly after. The hospital therefore knew about the municipalities’ demand regarding the dead-line for the hospital to contact the municipalities about patients ready for discharge before the weekends, which they also accepted as they understood why the municipalities saw this as necessary in order for them to ensure good patient care. One of the informants from the hospital said as a comment to this that this demand was something he welcomed as it could help in enhancing efficiency among the medical staff in the hospital as this dead-line would cause problems for the doctors and nurses if the hospital would be filled up with too many patients – both those patients who had been admitted and were in need of health services and those who could have been discharged and therefore clearing out beds for new patients. The informant meant that by enhancing the efficiency in discharging patients as soon as they were treated according to protocol would help in achieving the goal of reducing the number of corridor patients and hence the waiting lists for the hospital.

### 4.5 A wild card occurs

When the negotiation process was in its final stage, as the dead-line for finalising the contract was closing in, there was a wild card that disturbed the process slightly. The Ministry of Health and Care Services had sent out a note to the HT’s which stated that the municipalities and hospitals were not given any room to negotiate on the hospitals’ notification requirement for dischargeable patients. This note came as late as December 15th 2011, i.e. about two weeks before the contracts should be finalised in order for the municipal councils to hear, i.e. evaluate, and sign the contract by the end of January 2012. This meant in reality that the government interfered with the negotiation processes.
On the same day there was a municipal meeting with all the municipality’s represented where they discussed the contract. Representatives from the hospital sent the note over to one of the CAO’s present at the meeting and the note was discussed by the municipalities immediately. In this meeting there was also a representative from KS present. After discussing the matter in this meeting they decided, together with the hospital, that they would continue with the contract they had completed as it was, with the hospital having to contact the municipalities no later than three o’clock on Fridays for the municipalities to either take over the patients or pay for the following days of stay at the hospital, at least until they were told otherwise by the government. The hospital agreed on this as a temporary decision. The representative from KS also ensured that the matter would be discussed within KS, and it was KS that resolved the matter as they took the discussion with HOD and came to agreement that the government could not continue with this decision because the processes throughout the country had come too far for it to turn around at such a late stage in the process.

4.6 Equality and power in the negotiation process

One of the most important aspects of negotiation processes between the national and the local level in Norwegian politics is equality between the parties. The study by Kalseth and Paulsen (2008) showed there has been a tendency that municipalities did not feel that the equality was present and/or maintained in the hospital-municipality relationship in the process of making the voluntary contracts in 2007. This was confirmed by the municipal informants for this thesis. Also the informants from the hospital acknowledged this as a challenge during the process, but from their view this became an issue because the municipalities made it so. According to one of the informants from the hospital the municipalities maintained their position as “little brother” by not engaging themselves in the different processes that went on between the hospital and municipalities, which led the hospital to take initiative for both smaller and bigger projects resulting in dissatisfaction from the municipalities because they felt that the hospital was pushing initiatives on them – even when the original initiative was raised by health care workers in the municipalities. The municipal informants, on the other hand, expressed that the high degree of specialisation that the hospital have and the fact that they have only one purpose for their organisation, compared to the many purposes the municipalities have to deal with, made it easier for the hospital to be in control and
take charge over the municipalities in health care matters. The way the hospital saw it the municipalities clearly outnumbered them with 21 municipalities to one hospital, and even in meetings there were by far more representatives from the municipalities than from the hospital, and therefore the inequality should be in the municipalities’ advantage.

The two parties had each their strategy for enhancing their power. The municipalities main strategy seemed to be that they joined forces into one group that could “speak with one tongue” where they also could share their professional resources in order to get the best possible contract. The hospital’s strategy seemed to be to recruit staff for their new department for coordination from the municipal sector in order to narrow the gap of knowledge and understanding of how the municipalities’ health care system was organised. Still, the department could not compete with the number of competent staff in the municipalities.

It became evident during the data collection process for this thesis that the informants from both sides of the negotiation process viewed the other part to be the strongest one.

4.7 The outcome of the process

All of the informants agreed that the process had been hard but necessary as it both ended up with the parties having more trust towards each other as well as the parties agreeing on a contract which was made mandatory in the implementation process of the Coordination Reform. The informants also agreed on that is was reckoned to be a victory that the municipalities had been able to coordinate their interests and “speak with one tongue” which made it possible for the municipalities to end up with the same contract, i.e. eliminating envy and conflict between the municipal actors. This change also made it easier for the hospital to have a dialogue with the municipalities as they now had one joint actor to deal with instead of 21 individual entities.

The informants also stated that perhaps the greatest breakthrough in the process was that the CAO’s after quite some time had begun to participate in these kinds of health care matters. The informants from the hospital expressed a great deal of satisfaction as they were finally able to have the CAO’s interested in these matters and therefore that they
were more present in finding solutions to different challenges. The municipal informants also expressed that they now saw how important it was for both the hospital and the municipalities that the CAO’s engaged themselves in these kinds of issues which in this case had made it easier for the parties to complete the process of creating a new contract as this task now was higher up on the agenda in the municipalities.

There seemed to be a growing recognition and understanding among the informants about the other party’s point of view towards the health related challenges they face in their daily operation, and the gap between the parties seemed to be smaller after the negotiation process which again led to a better relationship between them.
5. ANALYSIS AND DISCUSSION

The stories the informants told during the interviews were surprisingly coherent. They very much acknowledged the parts of the story where the other party was critical of their actions and they commended each other for the outcome of the process. One of the informants expressed himself somewhat more positive in his version of the story than what the others did, but his story was also coherent with the others’, although it was necessary to “read between the lines” and to interpret some parts of his story in order to match the stories. This positive version of the story was surprising, as the version of the informant’s colleagues who was interviewed for this thesis was far more critical to the process. All informants expressed that the process had been challenging at some points but they all meant that the process had contributed to an improved cooperative relationship between the parties, and they therefore saw that the process was rather necessary to go through.

5.1 The negotiations

Negotiations are, as Pedersen (2007) described, basic forms of social interaction in both politics and the society, and a premise that must be present in order for negotiations to take place is that the parties’ interests are not too different. In the negotiation process studied in this thesis the parties had already expressed that they wanted to revise the voluntary contracts from 2007 before HOD presented the Coordination Reform in 2009 which were to include the element of mandatory contracts between the parties.

Pedersen (2007) also expressed that regarding negotiations one can distinguish between bilateral and multilateral negotiations. The negotiation process in the case of study was multilateral in the first phase of the process, then bilateral in the second phase. Before the municipalities were able to join forces there were as many as 21 municipalities and one Health Trust negotiating. After the municipalities had joined forces there was a joint municipal group creating a contract partially with the one Health Trust.

Jacobsen and Thorsvik (2007) stated that a premise for a negotiation to take place was that the interests of the two parties meeting could not be too conflicting, as well as a necessity of the parties to have some common interests that bring them together to find
a common solution. These premises seem to have been present in the case described in this thesis. The two parties, i.e. the municipalities and the hospital, were both obliged to begin a negotiation process as set forth by the government represented by HOD and they had also come to terms that it was a wish and need of revising the contract from 2007 regarding their cooperation and coordination. And so the negotiation process commenced.

As mentioned during the presentation of negotiations as a social phenomenon, a negotiation is a practical example of game theory and can be divided in two categories; static or dynamic negotiations. The negotiation described in this thesis seemed to be a dynamic process. The parties were able to respond to the other parties’ actions throughout the process, both because the parties were working together in the first phase of the process and because they later on in the second phase were able to respond to each others actions. This can be seen as a result of the fact that the process lasted from about 2009 to as late as about December 2011. When the first editorial committee presented their proposition, the remaining actors, mainly the CAO’s of the municipalities, were given a chance to respond, which they also did by refusing to give comments to the proposal. In the second phase of the process, when the municipalities took the lead, leaving the hospital out of the process, they also presented a proposition for a contract for the remaining actors, at that time the representatives from the hospital, to respond. The hospital responded to this by continuing to discuss the contract in the original joint group until both parties came to agreement on a proposition where the municipalities had several breakthroughs for many of their demands.

According to Jacobsen and Thorsvik (2007) negotiation processes can be either of a distributive kind or of an integrative kind; the distributive being about distributing a certain amount of resources leaving one party as the winner and the other as the loser, while integrative being more about achieving a win-win situation for both parties. In the negotiation process discussed in this thesis there seemed to be a differentiated view on this matter by the parties – at first. The hospital seemed to see the process as integrative while the municipalities expressed a view of seeing the process as more fitting in the distributive category, because they had more to lose and they expressed a worry that the hospital would ensure a contract which would leave the hospital in control over the financial resources of the municipalities.
“There was, for example, a suggestion that the hospital could discharge dischargeable patients to a nursing facility if they could only find one. Somewhere. Which would mean a hospital-control of the municipal purse that was unacceptable.” (Quote from the interviews)

This quote illustrates how the municipalities were quite sceptical to the proposition of the first editorial committee, the one led by the hospital, regarding the hospital’s routine for contacting the municipalities concerning patients ready for discharge and in need of more health care services provided by the primary health care services, which later led the one of the municipal regions to demand full stop in the negotiation process. One of the municipal informants reasoned the municipal walk-away as follows;

“For our part it was about getting control over the situation in relation to the municipalities’ obligations and being sure that we understood what was in it (i.e. the contract). The result was that we ended up with a much shorter version of the contract.” (Quote from the interviews)

As this quote illustrates, there was some insecurity, or even fear, among the municipalities that the contract proposed by the hospital led editorial committee would affect them, e.g. their financial status, as a potential result of the municipalities not fully understanding what they were signing. One of the elements for insecurity was concerns around the problem of how many dischargeable patients they would have to pay the hospital for keeping during the weekends if the hospital discharged the patients after the administrative staff in the municipalities had left the office for the weekend, leaving the municipalities unable to receive the patient. At this stage the negotiating process can be categorised as being integrative, because the municipalities feared that the hospital was too much in control of the process. The municipal informants expressed that they had worries concerning the power the hospital doctors had to discharge patients who were in need of more health care services that were to be provided by the primary health care service, without the municipalities being able to receive these patients. The municipalities feared that they would have to pay more money to the hospital as a result of not being able to receive the patients, making it hard to keep their municipal budgets for all the other services they also are required to provide for their inhabitants. This state of insecurity and fear changed when the process was led by the municipalities. But before this municipal led group was able to begin the process of creating the contract they needed to establish trust among the municipalities in the group. It should be
emphasised that during the data collection and while conducting the analysis for this thesis it became more and more evident for me that the parties did not seem to have as many differences and obstacles to overcome during the process as what they seemed to think that they had. Rather, the parties generally expressed that they both had the patient as a primary concern, and accompanying this concern there was also a concern of the practical arrangements and financial consequences that followed. The parties’ informants also seemed to have a rather realistic perception of what was possible to achieve in the process, but they expressed than they thought that the other party’s representatives had another perception that themselves. It is therefore a finding that there was a superficial disagreement that can easily be determined, if only the parties could see that they are not as far from each other in the negotiation process as they think.

“For me, about three quarters of the complexity in this, was the municipal coordination due to the high number of actors. 25 per cent was related to the hospital.” (Quote from the interviews)

The complexity the informant was referring to was reasoned in the water-work scandal. Thus, after the municipal actors had established enough trust in their own inter-municipal group in order to cooperate in the negotiation process the process of creating the contracts proceeded.

At this stage of the process the negotiation shifted to be more of an distributive type, as it seemed like the municipalities at that stage both understood the reform in a greater extent as well as they did not see the hospital as a threat anymore, mainly because the municipalities had completely taken over the process. The process was also distributive as a result of the very detailed manual for the contract, written by HOD, which left little room for winners or losers. The municipal editorial committee used the contract proposed by the hospital led group as a basis for the new contract proposal that was written and they had some informal contact with the hospital in order to keep them informed of the process, so the hospital’s voice was not completely left out. The hospital waited patiently for the municipalities in this stage of the process, and the informants from the hospital stated that they valued the increased engagement from the municipalities in such a great extent that they saw that it was worth the price if they let
the municipalities work without too much disturbance in order for them to come up with a contract proposal. The informants also stated that they were very happy with the revised contract the municipal actors presented for the hospital, so the patience from the hospital paid off. As a result of this there were no clear winners or losers of the negotiation process. Both parties seemed to view the negotiation process as distributive because they now had a common understanding of the impact of the reform and as they also got the same perception of the goal; enhancing quality of health care services for the patients. By enhancing the quality of the patient’s health care services they also enhanced their own situation with fewer patients in need of long hospital stays, which would lead to lowered expenses both for the municipalities and for the hospital. For the hospital the saving would come as a result of reducing the number of fines to the government for long waiting lists as well as inducing more DRG-points for new patients. For the municipalities the saving would mainly come from a reduction of the amount of co-financed hospital treatments and stays for their inhabitants.

Burns, Bradley and Weiner (2012) presented three approaches or strategies in negotiation processes where the goal is to seek resolution; compromising, competing and collaborating. In the first part of the process, with the hospital taking the lead, there seemed like the strategy for the hospital was collaboration. This is because both the municipalities and the hospital participated in the process with representatives from both sides, even though the municipal representatives had a varying degree of consolidation from their superiors. In the second part of the process there seemed to be a shift from first competing to later on compromising. The process was characterised by some competing elements because the municipalities quite obviously excluded the hospital from taking part of the process of writing the new contract proposal. By doing so it can appear that the municipalities showed little concern for the hospital in order for them to gain as much benefit out of the situation as possible. Later on in the process, partly due to the dead-line the parties were given by the government which was now closing up, there was a need of compromising on the parties different wishes and demands in order to arrive at the preferred outcome of the negotiation process which was that both parties would agree on the contract’s elements and thereby signing it. They simply had to give and take in order to come to terms on the contract in order to sign the contract.
Tactics such as adding issues, fractional issues and logrolling did not seem to be present, partially because there was a quite narrow negotiation space in the process due to the legislation which the contracts had to be matched to. The Act and the provisions made it very clear what the parties were to come to terms on and there was close to no possibility to present any issues to the negotiation process. The only thing was the demand from the municipalities that the hospital could not contact the municipalities about patients ready for discharge and in need of more treatment from the primary health care services. This demand seems to fall under the tactic of adding an issue.

The tactic of coming with an opening offer was on the other hand present in the negotiation process. The hospital led committee came with an opening offer to the municipalities to discuss when they presented their proposition of a contract in the spring of 2011. When the municipalities took the process in their charge they very much followed the outline of the proposition of the hospital led group. Also the tactics of forming coalitions was present. There was a radical change in the process when the municipalities formed their coalition. After this the municipalities felt stronger and more able to negotiate with the hospital. An important aspect of the process of forming a coalition was that the CAO’s got involved and were able to turn the municipalities’ work in the same direction, which also made the process easier to cope with the hospital as they now had one actor to deal with instead of 21 municipalities, in addition to the three districts of Oslo.

The tactic of walk-away or BATNA was also present. One of the municipal regions walked away, pulling the two remaining municipal regions with them. The resource the municipal actors was dependent on seemed to be financial control over the costs following dischargeable patients which would be very much influenced by the power the hospital’s doctors obtain of declaring patients ready for discharge without the municipalities being able to discuss the matter. The municipal actors understood that they could not in any way take over the responsibility or power to declare patients ready for discharge because they did not have the competence to take over this task from the doctors in the hospital. Thus, the option they used in order to obtain more control of the situation was to present their demand that the hospital would not declare patients who were in need of more health care services, mainly provided by the primary health care service, ready for discharge after three o’clock on Fridays. This way the municipalities
would have to pay for the entire weekend if they were not able to take over the patient after municipal office hours.

5.2 Structural aspects of the negotiation

There were several structural aspects that were easily detected during the interviews of the key informants regarding their story of the negotiation process. First off is the structure of the situation, or more precisely of the negotiation process. In the phase when the hospital was leading the process the meetings were held in the hospital facilities, while in the municipal led part of the process the meetings were held mainly in the municipalitys facilities and some meetings were held at the hospital. This had some impact of the process;

“I’m not very interested in sports, but there is something that concerns home ground and away ground. Also in negotiations there can be an advantage to be on home ground.” (Quote from the interviews)

This was a point that I had considered before this quote came in one of the interviews, because there is surely at least a symbolic aspect of where the meetings in a negotiation are held. We would all probably feel much more comfortable and at ease in places we know well, as well as feeling somewhat more tense when stepping into someone else’s territory, perhaps especially if there was a negotiation process taking place. This could have been an influential factor for the municipalities during the first phase of the process. It was mentioned under some of the interviews that the municipal representatives did not communicate much with each other, neither during the meetings nor between the meetings. Could that have been different if the meetings had been on municipal grounds? Not necessarily, but it could have had some effect on the process.

The actors participating during the two stages of the process was also something that caught my attention. The municipal CAO’s openly admitted that is was a bad prioritisation of them not to participate early on in the process when the hospital invited the municipalities to join the editorial committee which they were leading at the time. The CAO’s rather sent their heads of municipal affairs within the health sector to negotiate a contract on behalf of the municipalities, and these representatives did not
have the same degree of consolidation in each of their municipality. The informants from the municipalities also emphasised the importance of the support group they had established were they could take advantage of each other’s professionals, e.g. legal advisors. This group helped the municipal representatives to be more secure during the negotiation process, according to the informants. From the hospital the representatives were mainly from the Department of Coordination, and they had been recruited from the municipal sector and from the counties. These representatives had a lot of support from their top management, with a close dialogue with the hospital’s vice president. The representatives’ professional background also seem to benefit the hospital as they were more prepared for what was to come in the process, as the following quote from one of the informants from the hospital describes.

“A: I know the municipalities well. I know how the decision-making process works.
Q: So there were no surprises because of this?
A: No.”
(Quotes from the interviews)
the contract within the dead-line they had no other option than to follow the manual with all its considerations and elements.

“And I must say that it was extremely provoking that they on one side said that the contracts should be based on the good cooperative patterns which was already institutionalised and to follow these, and then presenting a manual which almost says “you should!”” (Quote from the interviews)

It seemed obvious from this quote, said by one of the representatives from the hospital, that the late arrival of this manual didn’t make the negotiation process easier for the parties. A representative from the municipalities expressed during one of the interviews that she felt that the government handed all the good cards to the hospital in this manual leaving the municipalities with a perception of being unequal in the process. These two representatives very much expressed the same feeling of the government intervening in the situation. It is impossible to predict how the situation could have turned out if the government had not presented this manual at such a late stage, but I cannot see how the government did the situation much better with the late arrival of the manual. It could have been that the manual in some areas was helping the parties coming to a joint understanding of parts of the legislation, but that was not expressed during any of the interviews.

Structural aspects about the parties, i.e. organisational structure, are very important in the understanding of the negotiation process. There is little doubt that the two groups of actors differ greatly in how they are structured organisationally. Municipalities have a very wide scope of activities which they have to provide for their inhabitants, while the hospital can focus on one activity; providing good health care services for their patients. Also the fact that municipalities are directly governed by local politicians due to the principle of local autonomy differs greatly from the hospitals which are governed by professional boards to report to the national government, more precisely to the Ministry of Health and Care Services. This implies that the national government can directly control the hospitals but not as easily control the municipalities. Some of the informants from the hospital implied that they felt like the hospital had been given “all the good cards” by the government as a result of the hospital being directly owned by the state government. Such a suspicion is not helpful in a situation that was already tense.
The representatives who met in the negotiation had different mandates while executing their roles. The municipal representatives had been delegated their mandate from the CAO who again had been delegated the responsibility of negotiating the content of the contract from the municipal councils. As the representatives who met in the meetings were not the ones who were to sign the contracts, which was rather the municipal councils, it must have been somewhat challenging to negotiate as they did not have too much direct contact with the local politicians during the negotiation process. The representatives from the hospital did, on the other hand, have a more close contact with their superiors who had the mandate of signing the contract. These differences may have had some effect on how the representatives executed their tasks and roles during the negotiation process.

The negotiation variant of the instrumental perspective seems to have been present in the case studied in this thesis, as there was both assertion of interests made, negotiations, and compromises present.

The expectation that I had regarding findings relating to structural aspects of negotiations were fulfilled. The organisational structure did affect the negotiation process because municipalities and hospitals are different in so many ways, both in purpose, scope, and how the two types of organisations are designed. Municipalities are local governments, while hospitals are owned by the state government. Hospitals only focus on health issues, while municipalities deal with health as one of many other obligations of services they have to provide for their inhabitants. As these two actors are different in so many and substantial ways it is obvious that the differences did have had an effect when the parties met.

5.3 Cultural aspects of negotiations

There were also cultural aspects that were pointed to as influential during the process, by the informants during the interviews. The municipal informants expressed a perception of feeling like an underdog compared to the hospital, while the informants from the hospital stated that this was to be expected because the municipalities had a tradition of expressing this. What this is based on is not obvious, but it is clearly an interesting aspect of the process, which the informants from both parties expressed as
something that influenced the relationship between the parties quite a lot. The informants were quite unanimous regarding the importance of the breakthrough, when the CAO’s understood the importance of their participation in the negotiation process. The CAO’s understood this due to the major impact the reform would have on the municipalities and they contributed a great deal in making the municipalities cooperating, which also resulted in the municipalities feeling more equal to the hospital in the process. There seemed to be a hope from both sides that the municipal feeling of being an underdog in the relationship towards the hospital now would be reckoned to be history.

Cultural aspects can be expressed by the informal values and norms that are embedded in the organisations. In the hospital there seemed to be a culture that the medical aspects were higher valued than politics and administrative aspects, while it seemed to be the other way around in the municipalities. This is not surprising, based on the purpose of these two organisations, with the municipalities having to provide a wide scope of services for their inhabitants which makes it very important to value politics and administrative regulations, while the hospital’s most important purpose is to provide good health care services. These aspects did, as all the informants clearly expressed during the interviews, affect the negotiation process. One of the informants who represented the hospital stated that the municipalities did not include representatives from patient organisations in their editorial committee, while the hospital was very determined in having representatives from such organisation present in the first phase of the process. The informants from the municipalities acknowledged this as something they were aware of, but it was not something they prioritised in the second phase of the process which they led.

The characteristics of the representatives were also an aspect that seemed to be of importance in the negotiation process. Informants from both the municipal sector and from the hospital emphasised the importance of including those who really wanted to bring something good into the process and who wanted to contribute in order to make the coordination and cooperation between the two parties even better. The representatives from the municipalities were hand-picked by the CAO’s and they all had a lot of knowledge about the primary health care sector, either as heads of municipal affairs within that area of politics or they had the position that many Norwegian
municipalities created as a response to the reform; coordinators (in Norwegian: samhandlingskoordinatorer). There seemed to be no doubt that professional knowledge was of great importance for those who were to represent the parties in the negotiation process.

The aspect of where the meetings during the negotiation process were held has been discussed in subchapter 5.2, regarding structural aspects of negotiations, but it is worth noting that this aspect also falls under the cultural aspects of negotiations. As the informant’s quote cited in chapter 5.2 stated it did have an effect on the process that the meetings in the first phase of the process were held in the hospital. If the representatives are acquainted with the physical location of the meetings they will most likely feel more relaxed during the meetings than if they are at a unfamiliar location.

The expectations that I had for the cultural aspects of negotiations being present were also fulfilled. The difference in culture in the two types of organisations that were to negotiate will affect the outcome of the process, in the same way that structural aspects will affect the process. These cultural aspects may not necessarily have made the process difficult, as I expected it to be, but it may have contributed to making some parts of the process somewhat challenging. Also the characteristics of the people who were active in the process did affect the process, and hence the outcome.

5.4 Power in negotiations

The power that seemed apparent in this process seemed to be derived from both structural sources, from cultural sources and from knowledge-based sources, and the informants from both sides almost consequently stated that it was the other party that had the advantage regarding power.

The structurally derived power seemed to be in position of the hospital, at least in the eyes of the municipalities. The hospital is closer to the national government, i.e. HOD and the parliament, which also decided that the Coordination Reform was to be implemented. Some of the informants from the municipal side of the case seemed to come with some hints indicating a perception of the reform and the legislation as
favourable in the hospitals advantage, which as I understood made them feel like the power in the negotiation process was unevenly distributed.

The cultural based power seemed to stem from much of the same reasoning as for structurally derived power, but in terms of the municipal representatives feeling like they were more often left in an unfavourable position than what the hospital was. This finding seemed to originate from the municipalities’ perception of their own position as an underdog or “little brother” of the hospital, which confirms the findings in the study by Kalseth and Paulsen (2008).

The knowledge-based derived power seemed to be in favour of the medical staff at the hospital, due to their exclusive power of declaring patients ready for discharge without the municipalities having much to say about the matter, which was in the hospital’s advantage. However, the informants from the hospital also expressed a municipal power derived from knowledge that the municipal informants did not seem to focus much on; that the municipalities had much more knowledge in the wider scope, in regards of seeing the whole picture of a patient’s health as well as rehabilitation of patients, and the care of patients, than the hospital has. This point was not mentioned by any of the municipal informants.

There was a significant shift in the power between the parties after the municipalities had joined forces, compared to the power held by the hospital. The municipalities went from being in the position where they usually waited for the hospital to take initiative for any types of changes, to becoming a stronger and more confident part which quite suddenly set the hospital aside, thus making them wait for the municipalities to determining what they wanted out of the process of making a new, binding contract. It can seem like the municipalities reduced the hospital’s power in the negotiation, or at least passified them more than what had been done before. Still, this seemed to be what made the main difference for the municipalities which led them to feel more in control of the situation and therefore more actively participating in the negotiation process. The hospital waited surprisingly patiently for the municipalities to create a new contract, but the informants from the hospital mainly expressed satisfaction of the negotiation process’ outcome which was very much a product of the municipalities’ strategy and hard labour. The inequality that has been present between the parties for a long time
does now seem to be less eminent, if not turned around to be in favour of the municipalities rather than the hospital.

The expectation I stated for the presence of power in negotiation was correct. This is not surprising as the expectation was inspired by the findings of the study conducted by Kalseth and Paulsen (2008). The two actors did have certain expectations regarding each other’s amount of power, and the initial inequality between the two parties did affect the process thus in a surprising way as the municipalities took control over the situation and turned it completely around.
6. **CONCLUDING REMARKS**

The negotiation process in order to agree upon, and sign, obligatory contracts between municipalities and hospital within a specific area in the south-east part of Norway was challenging. Still it ended well. The research question for this thesis was;

“We can be seen as the key factors that enhanced success in the negotiation process between a hospital and the municipalities in the hospital’s catchment area in the south-east area of Norway?"

Through the analysis and presentation of the results some key factors were detected. These will be presented below. I will come with some remarks regarding the study case and what can be learned from it, as well as some ideas for further research projects.

### 6.1 Main findings

Some key factors that seemed to enhance success in the negotiation process and its outcome were detected in the study being the basis of this case. The key factors detected;

- **CAO participation**: That the municipalities’ CAO’s eventually joined the process and through their participation lifted the work related to the Coordination Reform to be a more important matter than it had been previously.

- **Municipal alliance**: That the municipalities were able to form an alliance, and by doing so being able to speak with one tongue. This also made the process easier for the hospital which as a result of the municipalities alliance had a reduction of the number of parties to deal with from 21 to one. This also ensured that all the municipalities ended up with the same contract, and this is expected to reduce the chance of disputes among the municipalities at a later point in time.
• The hospital’s preparation: That the hospital had established a department solemnly to deal with coordination towards the municipalities. The staff of this department was recruited from the municipal sector and from the counties, and this was a strategy chosen by the hospital to improve their knowledge about the municipalities way of organising health care service production.

All of these factors were contributing to the success of the negotiation process, and the informants expressed that the process had been necessary in order to improve the relationship and the cooperative pattern between the two parties. The two parties were able to agree upon a contract that they both were satisfied with, according to the key informants of this study. The informants also expressed that even though they had been able to establish trust with each other and a contract that both parties could accept it was still a lot of work ahead of them in order to maintain the trust and the foundation for the contract. If the parties are able to maintain the trust towards each other, then the prospects of the Coordination Reform should be very promising.

6.2 Other findings

It was interesting to discover that the parties seemed to have a superficial disagreement with each other during the process. The informants gave rather clear indications of some mistrust towards each other based on, as I understood it, an expectation that the other party would have another view of the issues that were up for discussion in the negotiation process than they did themselves. What was interesting about this was that while I was listening to their stories it became evident that both parties actually were trying to reach the same goal concerning output of the contract and that they understood quite a lot of the difficulties of the process – at least after the CAO’s joined in the process. There were of course some differences in the perception of the process, but I still think that if the two parties had only heard the stories told the same way I did the superficial disagreement could probably have been reduced substantially and the process could hence have been less conflicted.
It was also interesting to hear how the informants had reacted to the wild card of the process – the letter from HOD where they tried to interrupt in the process by limiting the negotiation space by stating that the municipalities and the hospitals could not agree on other terms than what was described in the manual of the contract, regarding the transferral of dischargeable patients who are in need of more health care services provided by the primary health care services. It was quite clear that this was seen as an interruptive element in the process by both parties. The parties seemed to have favoured a somewhat looser format for the negotiation process than what was given by the Ministry, though it was unclear to what extent the format should be looser, and it was not appreciated that HOD interfered in the process in this way – especially not that late in the process, as was the case. It can therefore be concluded that this is an incident the national government should learn from in a way that they will leave the negotiation process to the parties and not interfere in this way, especially if the letter is not made official nor with a clear regulation regarding the contracts, and at least not that late.

6.3 Further research

The research project that led to this Master Thesis has shown to be a very interesting topic in the field of health politics research. This because the project has been an attempt to describe how the two group of actors that will have the greatest impact of the outcome of the reform, based on their coordination and relationship, have laid the foundation for a better and more organised relationship in regards of coordination of health care services. The approach of the study, i.e to study the two parties negotiation process, is in my opinion a fruitful approach to a field that definitely should be explored even more, especially in a potential evaluation of the reform’s implementation phase and its outcome. The use of instrumental and institutional perspectives, i.e. the structural and cultural aspects of the negotiation, was very useful in order to understand the mechanisms of the process, and these perspectives should definitely be used more in further studies as there was no doubt that many of the incidents and the responses and actions of the parties could be understood better through the use of these theoretical frameworks. My study can be seen as an early contribution of, hopefully, a series of studies of the main actors of the health care sector and especially the Coordination Reform.
Regarding further studies I believe it would be very interesting to conduct a follow-up study from this process to the next where the two parties described in this thesis were to negotiate over the remaining seven elements of the contract. It would be interesting to study the second negotiation to see whether the parties has learned from the first negotiation process, and if so how that affected the new process.

It would also be interesting to conduct a comparative study on negotiation processes in different parts of Norway to find similarities and differences, and to be able to draw more specific conclusions on e.g. the key factors that enhanced success of the negotiation process, as was this study’s objective. Another interesting study to conduct would be a study where other actors are included, such as HOD and KS, and even interest and professional organisations such as the Norwegian Medical Association or the Norwegian Nurses Organisation, in order to understand how these actors viewed the process and how or if they participated in any way.
7. LIST OF REFERENCES


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Appendix I

Invitation to participate in an interview in relation to a Master Thesis

I am a student at the Master’s programme Health Economics, Policy and Management at the University of Oslo, and I am at the moment working on my Master Thesis. The theme for the thesis is the implementation of the Coordination Reform as I wish to study the process concerning the contracts between hospitals and municipalities that they are instructed to agree on and sign by January 31st 2012, and especially how the process was experienced by the two parties, i.e. the hospitals and the municipalities. In order to limit the scope of the study I will focus especially on the process between Akershus University Hospital HT and the municipalities in this hospital’s catchment area. There has not been conducted many similar studies to this, meaning the results of my study will not be measured up against previous, similar results but rather stand as an explanation of a specific situation that can be interpreted/analysed in light of organisational theory, among others. The purpose is to give a contribution to the societal debate about the relationship between hospitals and municipalities in a coordinative perspective, and to potential later negotiations between two public parties.

In order to conduct the study I wish to interview those representatives from the municipalities and the hospital that was active and especially involved in the process. The information of interest for this study is how the parties through their representatives experienced the process and the potential negotiations. The method for collecting this information is interviews where the informant will be able to tell his or her story about the process, hence the interview will not be following a tight plan. I will be using a tape recorder in addition to taking notes whilst we speak. The purpose of using a tape recorder is solemnly to enhance the quality of the quotes, and the recordings will be deleted after the project has been finished. The interview will take about one hour, and we will decide the time and place together. Those quotes that will be used, or specific opinions or perceptions that are emphasised greatly, in the thesis will be checked with the informants before the thesis is handed in for evaluation.

Participation in the study is voluntary and the consent for the participation can be withdrawn as long as the study is in progress without any cause being needed. As a researcher I am a subject of confidentiality and must therefore treat all data confidentially.
Appendix I

If you would like to participate in an interview I would appreciate if you would sign the attached consent form and return to me.

If you have any questions you can contact me on phone number [redacted], or by e-mail to the address [redacted]. You can also contact my supervisor Lars Erik Kjekshus at the Institute of Health and Society on phone number [redacted], or by e-mail to the address [redacted].

The study is reported to the Data Protection Official for Research, at the Norwegian Social Science Data Services.

Yours sincerely,

Kjersti Hals
Appendix I

Declaration of consent:

I have received information about the study concerning the contract process between municipalities and hospitals in the implementation process of the Coordination Reform, and I wish to participate in an interview:

Signature: ............................................................ Telephone number: .................................
Appendix II

Interview guide

The interviews will not follow a tight arrangement, but rather appear as a conversation. The interviews will begin with the informant being asked to describe how he/she/the party experienced the encounter with the other party, as well as the actual process with subsequent (possible) negotiation situations. If there should be little progress during the interview, the following questions will be possible to use in order to direct the conversation to the “right track”:

- When did the process begin, as you saw it?
- Did you experience the voluntary contract from 2007 as good?
- Did you experience the hospital and the municipalities as equal parties in the negotiation process?
- How important was the patient perspective for your party? (Use of patient participation, etc.)
- Who represented your party in the process? Was there any change in who represented the party during the negotiation process?
- How much did the legal and financial consequences affect the party’s engagement in the process? Was the reform and the patient focus “sufficient”?
- Which party took the lead in the process? Were there any changes along the way in the process?
- Could you describe the process about the rejection of the first contract proposal? Why did not the municipalities want to comment the first contract proposal? Why were not the hospital’s representatives directly participating in the second phase of the process?
- How did the municipalities organize themselves, in both the first and the second phase of the process?
- Do you have any opinion about the power of the two parties?
- Who was present at the negotiations? Were the meetings held at a neutral ground?
- How was the communication during the meetings? Were there any differences between the parties?
- Were the parties equally prepared for the meetings? Did they obtain the same (amount of) information?
- Was the entire contract negotiated at once or were each element discussed separately? Were there any specific elements that were discussed more than others?
- How was the cooperation/coordination between the hospital and the municipalities before this negotiation process began?