The policy process in hospital mergers: The physicians’ perspective

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Abstract
Mergers of autonomous public hospitals have become increasingly common. In the policy process, the divide between policy makers and the hospital management leaves accountability for organizational outcomes obscure. Conveying correct information to the public is imperative from a democratic perspective, in order to enable the citizen to hold policy makers accountable in public elections. This paper compares public accounts by the hospital management, accounts by managers of medical clinics in the hospital, and accounts by the physicians, concerning the outcome of a hospital merger in Southern Sweden. Results from a survey to 663 physicians and 12 managers of clinics are reported. The response rate was 54 per cent among physicians and 58 per cent among managers. While hospital managers and managers of clinics (83.3 per cent) describe the merger as mainly successful, the survey reveals that 80.2 per cent of physicians consider it a failure. Perceptions concerning merger impact on care quality, efficiency, work environment and employee turnover are reported, revealing the same discrepancy. The study also reveals that neither physicians, nor managers of clinics, experience that there is a well-functioning dialogue between professionals and policy makers. Observations are discussed and it is noted that personal interests may influence managerial information strategies in the policy process, hindering citizens from correct information. More research on the feedback dimension of the policy process in hospital mergers is requested.

Keywords
Hospital mergers, mergers, professionals, public sector reform, policy-making, management
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1. Introduction

Hospital mergers have become increasingly common in the Western world over the past decades. A driver is the changing demographic structure, with an ageing population contributing to soaring costs for qualified public health care. Several studies (e.g. Bazzoli, LoSasso, Arnould, Shalowitz, 2002; Fulop, Protopsaltis, King, Allen, Hutchings, Normand, 2002; Bazzoli, Dynan, Burns, Yap, 2004; Kjekshus and Hagen, 2007) point at recurring failure to achieve the synergies that were expected from these mergers. It is also widely recognized in the more general body of research on mergers and acquisitions that at least half of all mergers can be considered as failures (Hubbard, 1999; Cartwright, 1998).

This paper is focused on the feedback dimension of the policy process in hospital mergers. Traditionally, public management has focused on governance issues in the top-down dimension from policy makers to practitioners. However, from a democratic perspective, it is also relevant to understand the feedback dimension from professionals to policy makers and the information conveyed to citizens. Hospital mergers encompass major risks, in terms of quality of care and work health, but also major financial investments. Communicating correct information from operations to citizens as well as policy makers is therefore imperative.

This paper draws on a combination of the M&A literature and the health care management literature. It aims to explore the feedback dimension of the policy process in hospital mergers, comparing accounts on progress make by managers and physicians. Findings from a survey at a hospital in the south of Sweden (Skåne University Hospital), which underwent a merger two years earlier, are reported. The study reveals that there are substantial differences between how managers perceive and report on merger outcome and how physicians perceive merger outcome. The study also reveals that neither physicians, nor managers of clinics, experience that there is a working dialogue between professionals and policy makers.

Possible explanations are discussed and it is concluded that because personal agendas may influence the information strategies adopted by managers on hospital level or clinic level, policy makers and citizens may want to consider also the experience of physicians. Further research in this area is encouraged.

The paper is organized as follows. First there is a section depicting the theoretical framework of the study. The research design is then reported and the case with the Swedish hospital merger is introduced. Findings (research questions 1-3 and 5) are reported in three sections, followed by a discussion (research question 4) and a section with conclusions.
2. Hospital mergers and the policy process

The policy process is traditionally described as a process where managers in the public administration are responsible for organizing operations so that public policies are implemented as intended and within the scope of the available budget. This includes balancing the values of democracy, efficiency and legality. Whereas the strength of professions such as physicians is occasionally pointed out as problematic, as managers attempt to implement changes in the health care sector, it must also be emphasized that the competence and the professional ethics of this group may be an asset in change processes.

With New Public Management and its emphasis on professional managers, the classic conflict between managerialism and professionalism (Ackroyd, Kirkpatrick & Walker, 2007) can be said to have shifted to the advantage of the former. Just like professionals, however, managers may have personal agendas. For example, they may experience a pressure to signal decision power, modernity, competence and success (REF). This makes the question of how performance is perceived and communicated by these groups interesting. From a democratic perspective, citizens must be provided with correct information in order to be able to hold policy makers accountable. Policy makers, as well, will need to have correct information, in order to be able to secure operations. Therefore, there has been a growing interest in ‘evidence-based policy making’, signifying a strive towards a more informed decision process (e.g. Sanderson 2002; Pawson & Tilley 1997; Davies et al 1993), thereby improving governmental effectiveness.

Two kinds of evidence can be distinguished in this approach to the policy process. First, there is evidence aimed to promote accountability. This aim is typically addressed by the establishment of numerous performance indicators, in order to have as full information as possible. Second, there is evidence aimed to promote improvement through more effective policies. By exploring the effects from policy interventions in social systems, also from a theoretical perspective, we can obtain knowledge that will lead to effective action, it is assumed. (Sanderson 2002.) This paper is focused primarily on the accountability dimension. In this dimension, and as regards performance indicators, we argue that quantitative measures designed by policy makers and management may miss out important effects from reforms on the social system – effects that may be important to the citizen. In a hospital merger, effects on the quality of care is such a parameter.

Finding trustworthy performance indicators, providing correct and nuanced information from the organization is also important in order to avoid that blame game that otherwise is common in a context of autonomous public agencies, in particular after reform failures (Weaver, 1989; Hood, 2002, 2007; Kelman 2005).

Finally, it should be mentioned that being able to voice criticism, is a matter of creating a culture allowing for whistle-blowing (REF). In the literature on hospital mergers, the experience of the physician has been somewhat neglected, and the case is the same as concerns the relation between professionals and policy-makers. We chose to address this dimension using the constructs of accountability and performance indicators. Accountability is a key aspect in democracy (Przeworski, Stokes & Manin 1999) and in order for the citizen to be able to hold policy makers accountable, they will need to be provided with accurate information on the outcome of public sector reforms. For this reason, performance indicators, in particular as expressed in public accounts, are important.

3. Research design

We have chosen to conduct a single-case study of a hospital merger. The approach adopted in this paper, exploring the feedback dimension of the policy process in hospital mergers, is rare. We would therefore like to see this single-case study as a pilot study, which future research can build upon, while increasing the number of cases.
Four research questions were formulated and each was addressed with a specific method. Questions and methods were the following.

RQ1: How do the hospital managers publicly describe overall merger outcome?
Method: Review of managerial accounts in the media.

RQ2: How do managers of medical clinics experience merger outcome?
Method: Quantitative survey questions.

RQ3: How do hospital physicians experience merger outcome?
Method: Quantitative survey questions.

RQ4: Is there a difference – and, if yes, how can this be explained?
Method: Data analysis and theory development.

RQ5: What is the quality of communication between physicians and policy makers? (How do policy makers gather information on merger outcome?)
Method: Quantitative survey question.

In order to respond to these research questions, survey questions were formulated as follows. Questions no. 1-5 aim to respond to RQ1 and RQ2. Survey question no. 7 aims to respond to RQ5. Within brackets, the number of survey questions in Appendix 1 are stated (the survey encompassed questions also in other areas than that addressed in this paper).

1. How do you experience that the merger has affected care quality at your clinic? (No. 17 in Appendix 1)
   [Likert scale from Very negative (1) to Very positive (5).]

2. How do you experience that the merger has affected efficiency at your clinic? (No. 18 in Appendix 1)
   [Likert scale from Very negative (1) to Very positive (5).]

3. How do you experience that the merger has affected the work environment at your clinic? (No. 19 in Appendix 1)
   [Likert scale from Very negative (1) to Very positive (5).]

4. To what degree do you experience that the merger has resulted in the loss of key employees at your clinic? (No. 22 in Appendix 1)
   [Likert scale from Very low degree (1) to Very high degree (5).]

5. How do you experience that the merger has functioned more generally at the hospital? (No. 21 in Appendix 1)
   [Likert scale from Very bad (1) to Very good (5).]

6. There is a well-functioning and trustful dialogue between hospital physicians and regional policy makers. (No. 27 in Appendix 1)
   [Likert scale from Strongly disagree (1) to Strongly agree (5).]

The merger of two university hospitals in the south of Sweden was selected as a case study. The merger was implemented January 1\textsuperscript{st}, 2010. Hence, two years after the reform, we reasoned, would be a reasonable time to conduct some kind of evaluation. After January 1\textsuperscript{st}, 2012, the hospital management would resign due to retirement and for this reason, it was important to distribute the
survey no later than towards the end of year 2011. The merger of the two hospitals, situated in Lund and Malmö, resulted in what is today referred to as the Skåne University Hospital (SUS, in Swedish Skånes universitetssjukhus).

The survey was distributed November 3rd 2011 to 663 physicians at 12 hospital clinics and 355 of these responded, resulting in a response rate at 54 per cent. An almost equal survey (one question was removed as it was irrelevant) was distributed to the managers of the same 12 medical clinics. Out of these, 7 managers responded. Everyone was allowed to be anonymous.

4. Skåne University Hospital (SUS)

Skåne University Hospital was formed January 1st 2010, after decades of political deliberations. The decision to form the hospital was taken very rapidly and unexpectedly. It had been announced by both policy makers as well as managers that there would be no merger. Instead, they only wanted the hospitals to chose what clinics were considered key in their operations. This was referred to as ‘profiling’.

Since 2009, there had been a project (ProLuma) for this profiling. It aimed to settle how clinics at the two hospitals could divide operations between them, moving clinics in one or the other direction. There had been a rage of protests against the lack of an initiated analysis in these decisions and a major management consultancy had been given extensive influence.

After the decision to merge the two hospitals was made, the region was charged with a lack of compliance with legislation and the decision had to be made re-taken some time later. However, integration efforts continued rapidly.

SUS is today one of the largest hospitals in Europe. Criticism against the merger process have been extensive and issues and protests are continuously reported in the media. AT the same time, managers and policy makers have been firm in their ambition to continue integration efforts and managers have countered criticism with accounts on progress.

5. Accounts on progress

In a journal article June 2011 (Sjukhusläkaren), the hospital management was asked to respond to criticism against the merger approach adopted at SUS. The two deputy hospital managers Arén and Ekström responded that the change process was not at all as centralized as interviewees described it. The article explains:

‘They do not believe that any serious mistakes have been made after the 1st of January 2010. The change process, they argue, has been allowed to enroll over time:
- What has been highlighted in the debate concerns primarily the process before the merger, aiming to profile the university hospitals in Lund and Malmö against each other (Proluma). A lot of this work has been successful, according to our opinion (…)).
- At the same time it is obvious that there are problem areas, such as the Eye health care.’

[Also other management accounts will be added to this section as the paper is developed.]

In the survey to physicians at SUS, they responded according to Table 1. Table 1 also depicts responses from managers of medical clinics (because there were only responses from seven managers, these would normally not be converted into percentages, but in order to facilitate comparisons, this has been conducted in the table).

Results reveal that 60.5 per cent of physicians experience that the merger has had negative effects on the quality of care at their clinic, while the corresponding number is 28.6 per cent
among managers. Many managers experience that the merger rather has had a positive impact in this regard – 42.9 per cent, as compared to 3.0 per cent of physicians.

None of the seven managers believe that the merger has had a negative impact on efficiency at the clinic, whereas 62.5 per cent of physicians believe that it has.

A majority of physicians – 72.5 per cent – of physicians experience that the merger has had a negative impact on the work environment at the clinic. Managers do not agree. Only 14.3 per cent of managers experience a negative impact in this regard. On the contrary, many managers (42.9 per cent) believe that the merger has had a positive impact on the work environment. The corresponding number among physicians is 6.2 per cent.

Only 14.3 per cent of managers believe that the clinic has lost many key employees following the merger. The corresponding number among physicians is 45.2 per cent.

On the more aggregated level, 83.3 per cent (6 out of 7) managers believe that the merger process at the hospital has been successful, whereas no manager considers it a failure. Among physicians, 80.2 per cent believe that the merger has not been successful. Only 4.9 per cent of physicians consider it a success.

Finally, as concerns communication between physicians and policy makers, managers and physicians agree, as they state that this cannot be considered well-functioning.
Table 1. Responses from survey to physicians, as compared to responses from survey to managers of medical clinics.

<table>
<thead>
<tr>
<th>Question*</th>
<th>Group of respondents</th>
<th>Negative/do not agree (1-2)</th>
<th>Hesitant (3)</th>
<th>Positive/Agree (4-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (App. 17)</td>
<td>How do you experience that the merger has affected care quality at your clinic?</td>
<td>Managers of medical clinics</td>
<td>28,6%</td>
<td>28,6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physicians</td>
<td>60,5%</td>
<td>36,5%</td>
</tr>
<tr>
<td>2 (App. 18)</td>
<td>How do you experience that the merger has affected efficiency at your clinic?</td>
<td>Managers of medical clinics</td>
<td>0,0%</td>
<td>28,6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physicians</td>
<td>62,5%</td>
<td>32,4%</td>
</tr>
<tr>
<td>3 (App. 19)</td>
<td>How do you experience that the merger has affected the work environment at your clinic?</td>
<td>Managers of medical clinics</td>
<td>14,3%</td>
<td>42,9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physicians</td>
<td>72,5%</td>
<td>21,3%</td>
</tr>
<tr>
<td>4 (App. 22)</td>
<td>To what degree do you experience that the merger has resulted in the loss of key employees at your clinic?</td>
<td>Managers of medical clinics</td>
<td>85,7%</td>
<td>0,0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physicians</td>
<td>34,3%</td>
<td>20,6%</td>
</tr>
<tr>
<td>5 (App. 21)</td>
<td>How do you experience that the merger has functioned more generally at the hospital?</td>
<td>Managers of medical clinics</td>
<td>0,0%</td>
<td>16,7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physicians</td>
<td>80,2%</td>
<td>14,9%</td>
</tr>
<tr>
<td>6 (App. 27)</td>
<td>There is a well-functioning and trustful dialogue between hospital physicians and regional policy makers.</td>
<td>Managers of medical clinics</td>
<td>100,0%</td>
<td>0,0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physicians</td>
<td>92,9%</td>
<td>5,4%</td>
</tr>
</tbody>
</table>

*) Survey question in Appendix 1 stated within brackets.
6. Discussion

Survey responses and a media review [to be developed] reveal that merger outcome is experienced very differently by physicians on the one hand and by managers at clinics and the hospital management on the other hand. How can these results be explained? We shall suggest a number of possible explanations.

First, accounts by physicians may mirror a more general frustration with a merger process which was conducted with very little influence by this profession. Along this line, the differences in the responses by managers and physicians may be due to a lack of information on the side of physicians. While managers need to handle various performance measures, physicians may not have access to these calculations.

Second, accounts by managers may reflect a sense of loyalty to the hospital management and to the policy makers, who may expect them to convey this message. They may also have a personal interest in doing this, for example in order to be allowed to stay at their position and in order to avoid drawing negative attention to the clinic.

Third, it may be considered as a professional tactic by managers in a change process to communicate progress, regardless of how the change process actually enrolls. In the literature on planned organizational change (e.g. REF), this approach is often recommended, perhaps partly because this literature is based primarily on studies from the private sector, where the democratic perspective is not important.

Regardless of explanations, findings indicate that citizens may not be provided with the accurate information on reform outcome, when this information is distributed only by policy makers or managers. Accountability is important for a well-functioning democracy (Przeworski, Stokes & Manin 1999) and for this reason, the problems highlighted by this study are serious.

7. Conclusions

This paper suggests that managers in public sector reforms, such as hospital mergers, should be seen as actors with their own agendas and merely one out of many stakeholders, providing policy makers and citizens with information. Incentives for managers may differ from those among professionals. Whereas managers have an interest in showing a strong financial budget and also in showing that they are proactive and strong leaders, professional norms among physicians emphasize the quality of the provided services. In order to combine financial and quality incentives, and allow accountability, the policy process can be strengthened by policy makers attending to the feedback from both these groups.

Survey data will be analyzed further (for example on clinic level) in our continued research and comparisons will also be made to findings from another recent hospital merger in Sweden, as reported by Choi, Holmberg, Löwstedt and Brommels (2011).
References:
Sjukhuslåkaren, June 2011.