Innovating healthcare services: a matter of collective sense making?

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Abstract
This study is part of research effort to gain more insight into innovation processes in healthcare. It deals with introduction of a new center of rehabilitation services located in Oslo area, intended to meet the existing demand and improving the quality of the rehabilitation services. We have been following the development of the unit from the beginning by conducting interviews and observing meetings involving several actors representing different related healthcare organizations. Despite the apparent need of the new service and the support of policy makers, two years after the opening the new center capacity is utilized to about fifty percent. The case is revelatory of factors that enable and inhibit innovation in healthcare services. We focus on and discuss in particular the role of constructing a collective meaning among the different interacting actors as a critical factor when a new service is put in place.

Keywords: service innovation, inter-organizational network, interaction, actors, healthcare, sense making

INTRODUCTION

Healthcare industry is in most western countries an important and growing sector of economy. As the healthcare sector is demanding an ever increasing share of public money, it is nowadays a common view that the sector needs substantial innovation to make it sustainable. Policy actors and administrators of the welfare state at various levels are thus active in promoting and sustaining innovation in various segments of healthcare. New forms of organization are introduced and emerge in this sector in response to the demand for better services and more cost efficient organizational solutions. Experimenting with new solutions is challenging with a consequent increase in interest among scholars to understand better what hinders and facilitates the process (Chuang, Jason & Morgan, 2011).

There is a rather steady stream of research on innovation in healthcare that has shed some light on various aspects of innovation in such a context (Greenhalgh et al., 2004). There is a stream of research on innovation in healthcare that evidenced that healthcare service innovations tend to involve numerous organizations and various actors at different levels (Lindberg, Styhre, & Walter, 2012). This involvement of a number of actors with different agendas often makes the introduction of innovations in healthcare services a relatively complex process, difficult to monitor and the outcomes difficult to foresee.

Over the last ten years in Norway there have been notable attempts to reform and innovate the organizing of the healthcare. The introduction of the so called Coordination Reform in 2009 implies re-allocating of activities and responsibilities in particular between specialist care (hospitals) and primary care (local care provided by municipalities). As a consequence various novel organizational solutions emerged at the interstice of specialist and primary care. Outcomes of this effort to innovate the organization of healthcare, has not always been the intended ones and the innovation solutions have been transformed in the process. In parallel there has been a considerable amount of research aiming at investigating the process and its outcomes (e.g. Lyngstad et al., 2014; Romøren, Torjesen, & Landmark, 2011).

The empirical setting of this paper is the Norwegian healthcare sector, more specifically the municipal rehabilitation unit at Aker Health Arena (AHA) in Oslo. The paper deals with introduction of a new organizational unit of intensified day rehabilitation service provided by the municipality. The unit was established to meet the demand for multidisciplinary intensified day rehabilitation for elderly after stroke and elderly orthopedic patients with co-morbidities. We have been following the development of the unit practically from the beginning. Two years after the opening of the new center the unit's capacity is utilized at times to about fifty percent. The case can be used as revelatory of factors that enable and inhibit innovation in healthcare services. The research question that guided our study was: *What are the critical issues in introducing service innovation in a healthcare context?* Since the new unit is a part of a broader network of activities, which in total constitutes the patients rehabilitation pathway, the specific question we examined is: *how does the new unit relate to the pre-existing organizations and departments that are supposed to cooperate with the emergent unit?*

In the next section of the paper we outline the theoretical framework guiding our study that draws largely on the analytical concepts elaborated in research on inter-organizational networks in the IMP tradition. In the section that follows we discuss the methodology of our empirical study and present the case of the rehabilitation unit at Aker Health Arena. In the last two sections of the paper we first discuss the case and then formulate our conclusions with regard to the critical issues in introducing service innovation in healthcare. We focus on

the role that constructing a collective meaning among the interacting actors plays in the introduction of the innovation.

THEORETICAL FRAMEWORK

We approach the healthcare sector focusing on the inter-organizational relationships since from an organizational point of view healthcare is a complex network of organizations and actors who engage in interdependent activities and make use of heterogeneous resources. We are drawing on some concepts and frameworks developed in the IMP stream of research on inter-organizational networks (Håkansson & Snehota, 1995, Håkansson et al., 2009) and, in particular, on studies of innovation processes in such a context (e.g Håkansson & Waluszewski, 2007; Hoholm & Olsen, 2012; La Rocca & Snehota, 2014).We also draw on the ever more numerous studies dealing with the process of introducing innovation in healthcare (e.g. Tzannis, 2013; Engesmo & Tjora, 2006; Mørk, Hoholm & Aanestad, 2006; Jensen & Aanestad, 2007; Nicolini, 2010; Mørk et al., 2012).

Taking a network perspective three issues appear to emerge in studies of innovation. The first is the emphasis on the need to integrate the new solution in the pre-existing network of actors, activities and resources (Håkansson & Waluszewski, 2007) always based on certain specific aspects of connectivity and interdependence (Henneberg, Gruber, & Naudé, 2013). When innovation involves new ventures (or new organizational units) relating and creating new inter-organizational relationships becomes a central and strategic issue (Johanson & Vahlne, 2011; La Rocca, Ford & Snehota, 2013). The question put at centre by this research is in particular how the introduction of a new solution (organization/venture) fits with the existing network of activities, resources and actors (Harrison & Waluszewski, 2008).

The second issue that comes to the fore in studies of innovation processes is the extensive interaction needed when developing new relationships between organizational actors. Introducing an innovation involves interaction among actors who have different interests, agendas and network positions and various studies have shown that extensive interaction is as a condition for introducing an innovation (e.g. Håkansson & Waluszewski, 2007). This need for extensive interaction when developing new inter-organizational relationships reflects the uncertainty about various aspects of the new solution among the different actors involved. A common perception and understanding of the innovation solution has to emerge and often needs to be negotiated and jointly constructed by the parties (Jensen & Aanestad, 2007). Consequently the innovation process appears as non-linear and rather iterative. The iterative process of innovation also causes the innovation solutions to become transformed in the process (Hoholm, 2011). Innovation are new solutions brought into use which makes the users crucial in the process of innovations since the new solutions will have to become embedded in the already established resources in the user setting (Håkansson & Waluszewski, 2007; Harrison & Waluszewski, 2008). Embedding requires interfacing the new and the already established resources which requires adaptation (Baraldi & Strömsten, 2006). In order to embed innovations into user settings users have to understand the new solution and the consequences it will have for their resources and activities which are difficult to assess beforehand and involves confronting different views and some learning, often through trial and error.

The third issue is the importance of the social and political dimension of the innovation process. The need for interaction leads to the importance of the social dimension of the innovation process rather than simply of the instrumental dimension of the new solutions (Van de Ven et al., 1999). Service innovations usually involve high level of ambiguity and

uncertainty since they are affected by the variability of human characteristics. Service innovations involve a change in the relationship between service provider and their users, and many of the features of this process are intangible with high level of tacit knowledge (Hartley, 2012). The social and political dimensions of the innovation process, rather than the instrumental and economic dimensions, have been shown to be often dominating in the innovation process in healthcare context (e.g Nicolini, 2010). The importance of the social and political dimensions of the innovation process leads to the need to consider the communication processes in interaction and the importance of making sense of the innovation (Jensen & Aanestad, 2007). Innovator's knowledge of the meaning of the new solutions is often incomplete and a usage for the solution needs to be created. The user may have ideas about the value of the new solutions which the supplier is unaware of; therefore new solutions are created in interaction through a process of collective sensemaking. Sensemaking is commonly understood as process in which individuals or groups attempt to interpret novel and ambiguous situations (Weick, 1995) and collective sensemaking occurs when individuals exchange provisional understanding and try to agree on their interpretations and on a course of action (Weick, Sutcliffe & Obstfeld, 2005).

Innovation research in a public sphere setting, needs to take into account the wider political and policy context in which innovation takes place, if not it will risk to miss on explaining and understanding how innovation affects aims, behaviors and understanding (Hartley, 2012). The importance of the social and political dimensions of the innovation process and the centrality of the process of constructing a collective meaning, appears to be amplified in innovation in public context because of the intangibility of the service innovation solutions and the need to mobilize a set of different actors to achieve the service innovation (Miles, 2004; Nijsen et al., 2006). These aspects of innovation in service are clearly present when innovating healthcare services (Cantù et al., 2012; Tzannis, 2013). Interaction between actors, relationships and resources that is emphasized for business networking appears equally central in service context and the specific systemic structures based on interactions, have led to propose the concept of service network (Scott & Laws, 2011). It is an established theme that services arise from the interaction between providers and customers and warrants the application of the network perspective on innovation in services. Indeed the health sector stands out as a complex network of activities and actors engaged in interdependent activities and making use of heterogeneous resources. For this reason an inter-organizational network view looks suitable to our case.

Against this background we aim to analyse the process of introducing a new service organizational unit in healthcare and to identify critical factors enabling and/or inhibiting the integration of a new organization in an existing network of healthcare actors. Consequently, we will rely on the inter-organizational network perspective in analysing the case of introduction of a new and innovative organization unit for rehabilitation services and its outcomes two years after it has been set up.

METHODOLOGY

Our research is concerned with identifying critical issues in implementing service innovation in a healthcare setting. Our study is inductive and explorative in nature, and we use a qualitative interpretative approach. This study is part of a larger research project on service innovation in healthcare sector at various sites. One of the sites explored in this project is the specialized rehabilitation unit located at Aker Health Arena (AHA) in Oslo. The methods used are observation, semi-structured and explorative interviews, and document analysis.

Participant observation has been a major activity in exploring the process of integrating the new unit into the existing network of actors. We observed meetings that included participants (see table 1) from both the hospital and the municipality side and were concerned with planning and discussion related to the development of the "collaboration arena". Central themes in these meetings have been how to develop synergies across organizational boundaries by being co-located, creating a context where various parties can be partners in activities taking place in physical facilities (buildings) owned by Oslo University Hospital (OUS). Extensive field notes were taken in all the meetings, using the 'double diary' principle, with reflection notes written in the margin. We have used historical materials to map what happened before we started our project in the field (merging of hospitals and background of the Coordination Reform). In addition we have read meeting minutes, and project and policy documents to better understand the broader context of the healthcare sector and AHA.

Table 1. Overview of the observations

Type of meetings	Number of meetings	Participants in meeting	Theme	Time frame
Rehabilitation network meeting	4	10 -12 leaders representing rehabilitation located at AHA or have related activities to AHA; Geriatric resource center (OK), Sophies Minde Orthopedi (OUS), Specialized Rehabilitation (OK), Rehabilitation (OUS), - representing rehabilitation or related profession.	Synergies, rehabilitation pathway, co-location and build relationships.	Started to follow fall 2013 ->
Project meetings AHA	12	Project leader from OK, projects participants from OK, Sunnaas (Collaboration director) and OUS (coordinator from OUS in to AHA)	Developing AHA incl. all activities, synergies, rehabilitation pathway	Started to follow spring 2013 ->
Steering group Collaboration Arena Aker	2	Steering Committee for Collaboration Arena Aker is led by the Municipality of Oslo. The steering committee includes representatives from hospitals in the Oslo area, municipal agencies and city districts are represented, as well as user organizations and employee organizations.	Developing AHA, synergies, rehabilitation etc.	Started to follow spring 2013 ->

We have conducted 11 semi-structured and 10 explorative interviews related to the rehabilitation practice both from the hospital side and the municipality side. The interviews were open-ended, recorded and transcribed, and lasted between 45-120 minutes. Table 2 lists the informants that are cited in the case description.

Table 2. Overview of informants

Informant	Role, organisation
1	Section leader, rehabilitation OUS
2	Department leader, clinical service OUS
3	Specialist, rehabilitation Aker, OK
4	Project leader, Aker collaborative arena, OK
5	Project advisor, Aker collaborative arena, OK
6	Director, City Council department for elderly and social services, OK
7	Order office, city district
8	Ergoterhapist, city district
9	Fysioteraphist, rehabilitation Aker, OK
10	Order office, city district

The interviews focused on the co-location, Coordination Reform, collaboration, relationship between hospital and municipality, rehabilitation treatment, expectations, opportunities and constraint related to collaboration, regulations, patient-centeredness, ICT etc.

In our analysis we looked through the field notes and the transcribed interviews to search for patterns in the material. We have used Excel to code the material preliminary to identify controversies, similarities and differences. We have had an iterative process where we went from findings to theory and then conducted more field work to better understand the phenomena. We will in the following months spend more time in the field and conduct additional interviews and observation to further explore the emerging themes in our material. Limitation with our study is that there are several sites and many actors involved in the process, and as with any ethnographic study we have not been able to be present in all the places at the same time, and therefore important events can have taken place at other places than those we were at.

CASE STUDY

This case study is related to the Coordination Reform in Norway, and the merging of Oslo university hospitals, and the ensuing organizational changes going on, in particular the establishing of Aker Health Arena.

The Norwegian Healthcare Sector

We will start with a brief introduction of the Norwegian healthcare sector, and how it is organized. The sector is built around the principle that everyone should have the same access to healthcare services regardless of socio-economic position and geographic residence. The healthcare system is structured on three levels: 1) National/state level; The Ministry of Health and Care Services; 2) Regional level; four regional health authorities (RHA); 3) Municipal level; 428 municipalities. The Ministry of Health and Care Services has the overall responsibility for health policy, public health, healthcare services, municipal services for the elderly and disabled, health legislation and parts of social legislation in Norway. The four RHAs and the municipalities are responsible for the provision of services. RHAs are responsible for specialist health services and ensure that the inhabitants receive the specialist services they are entitled to. The municipalities are responsible for providing primary care. The division of responsibilities between the RHAs and the municipalities is related to the degree of specialization of services. Specialist services include somatic and psychiatric hospitals, outpatient clinics and treatment centers, training and rehabilitation institutions, institutions of interdisciplinary specialized treatment for drug abuse, pre-hospital services, private specialists and laboratory, and radiology activities. The municipalities are responsible for a number of services such as health clinics, school health services, general practioners (GPs), mental health work, home care and nursing homes.

The Coordination Reform in Norway

Improving coordination between the primary and the secondary healthcare levels has been on the political agenda in Norwegian healthcare policy for the last decade (Romøren, Torjesen, & Landmark, 2011). In 2005 a government report (HOD 2005) evaluated the collaboration between the primary and secondary level, and contributed to get the politician’s attention towards the need for enhanced collaboration. The report and the expected future challenges due to the increasing number of elderly in the coming decades, resulted in the Report No. 47 (2008 - 2009) 'The right treatment at the right place at the right time', the so called

Coordination Reform (HOD 2009a). The reform includes descriptions of action to develop a sustainable health sector, and have received broad support in the Storting (the Norwegian Parliament). The implementation started 1st of January 2012, and intends to gradually restructure the Norwegian healthcare sector. The overall aims of the reform are to prevent more, treat earlier and interact better. Patients and service users should receive the right treatment at the right time, in the right place through a holistic and coordinated service provision. The reform aims at developing the municipalities and move responsibility and tasks from the specialist level to the primary level. This is expected to pave the way for the specialist healthcare to concentrate more on specialized services and to de-centralize more treatment to local municipal services closer to where the patient lives.

'The increased resources must to a greater extent go towards developing services in the municipalities. The municipalities should be rewarded for investing in prevention in order to reduce the need for specialist health care services. And there should be incentives for hospitals and municipalities to team up…' (HOD, 2009b)

The reform emphasizes that the municipalities should increase their efforts towards prevention and more efficient use of resources to reduce the total need of specialist services. Objectives described are (HOD 2009b):

- Improved quality of life for the individual and reduced pressure on health care by focusing on health promotion and prevention.
- Reduced growth in the use of hospital services in that a greater share of health services is provided by municipal health services - provided as good or better quality and cost-effectiveness - for the benefit of patients.
- More comprehensive and coordinated services to health service users through binding collaboration agreements and the agreed patient pathways.
- To ensure the sustainable development of the health sector, by contributing to the efficient use of resources.

Concurrently with the municipal healthcare services being strengthened and developed, the specialist health will be reorganized. Assessment and treatment of frequently occurring conditions shall be decentralized where possible, and assessment and treatment of rare-occurring disorders should be centralized where necessary to ensure good quality and resource utilization.

The economic incentives following the reform have been mainly the introduction of co-financing and transfer of financial responsibility for inpatients ready for discharge. Co-financing implies that the municipality will cover part of the cost when the inhabitants are hospitalized, aiming to get municipalities to take more responsibility for the inhabitant's health, and become more aware of the importance of promote health, prevent disease, and build local offers. The transfer of financial responsibility for inpatients ready for discharge builds on the experience that many patients remain in hospital even when they are ready for discharge, because the municipality does not have a suitable treatment to offer them locally. With the Coordination Reform the municipalities have the financial responsibility for the discharge ready hospital patients from day one, and get funds transferred from the hospitals to establish services for these patients. Offerings may include short-term stays in municipal institutions or enhanced monitoring in the home. Despite some regulatory incentives and legislation, the reform is described as a 'direction reform' which indicates direction of the desired development, but allowing for variations and thus open for local variations (Ramsdal,

2012). In the following paragraph we describe the background for development of a collaborative health arena, which is central in the implementation of the Coordination Reform in Oslo.

The emerging of a collaboration health arena

On a regional level the East and the South Regional health authorities merged in 2007, based on the reasoning that an integrated ownership and responsibility across the two regions would lead to better management and coordination (HOD 2007). This became South-Eastern Norway Regional Health Authority (HSØ[1]), one of the four RHAs in Norway. In the mid 2000's it was decided that when the construction of a new hospital, Akershus University Hospital (Ahus), about 16 km from Oslo, was completed in 2011 a patient base of 160,000 should be transferred from the former Oslo hospitals to Ahus. Related to this, HSØ started a project named the Capital Process in 2008 with the aim to investigate the future hospital services to the population of Oslo. The project was initiated for several reasons: One was that opening of Ahus would lead to a smaller patient base for the former Oslo hospitals, and in 2008 the board of HSØ decided to merge the existing Ullevål University Hospital, Rikshospitalet University Hospital (including the Norwegian Radium Hospital) and Aker University Hospital into the health enterprise Oslo University Hospital (OUS). The declared aim was to give patients better services, and bring together professionals and resources and thus to make OUS a locomotive in specialized treatment, research and innovation, in addition to achieving economies of scale. The 1st of January 2009 the hospitals formally merged, and from 2010 the hospitals have common management, administrative functions and general clinics. OUS is one of the biggest hospitals in Europe, with 20,000 employees and a budget of about 1,3 billion Euros.

Due to the transfer of patients to Ahus, OUS had to adapt to a smaller population and the board of OUS decided in February 2010 that the hospital activity at Aker University Hospital premises were to be reduced and eventually phased out. This included a relocation of the clinical activities to other hospital sites and resulted in liberated space of about 53 000 square meters. Aker was previously a local hospital for 180 000 residents and acute surgical emergency for 270,000 residents, and the negative public reactions to closing down Aker Hospital site were massive. 40,000 people signed a petition supporting continuing operations, and the city district committees as well as a unified City Council supported the claim. In spite of the protest, the process continued and most of the clinical activities were relocated, except a few due to lack of space in other locations. The buildings continued to be owned by OUS, and there were discussions of selling the buildings for building apartments on the premises. Political pressure related to closing down Aker hospital and the introduction of the Coordination Reform can be seen as background factors that led to the decision of establishing a "collaboration arena" in the former hospital buildings of Aker, rather than selling the buildings.

In August 2010 the former Health Minister announced in media that the municipality and HSØ should work together to establish a collaborative arena for lifestyle diseases, chronic illness, rehabilitation and other health services in the buildings of Aker. Then in November 2010 HSØ and OUS agreed to develop a "collaboration arena" between the specialist sector and Oslo municipality (OK) at the Aker property (Oslo Universitetssykehus, 2010). HSØ and OK agreed that Oslo will be a pilot in building positive content in the Coordination Reform,

[1] We use the acronym HSØ, which is the abbreviation formed from the Norwegian name of the organisation Helse Sør-Øst.

and in forming a ‘future-oriented healthcare offer for the citizens of Oslo at AHA. The project mandate (Oslo Municipality, 2011) was approved by the steering committee in September 2011, and the project "Collaboration Arena Aker" was established for 2011-2014. The main objective has been to provide appropriate patient groups with the right offer at the right level, and thereby contribute to prevent and/or reduce health problems for the individual in accordance with the Coordination Reform. Further it aims at a renewal of existing services and development of a solution that enables future health challenges to be met in an innovative and close cooperation between hospitals and municipalities. OUS formulate the enterprise idea for Aker to be a healthcare facility where specialist and primary care are working together in the same location, coordinated toward the relevant patient and user groups. And that the services will be offered across Oslo's city districts based on well-developed user participation and with the aim of achieving better quality of patient care (OUS, 2014). In this paper we zoom in on one of these initiatives, that aims to renew the existing services within rehabilitation for the inhabitants of Oslo; a municipal intensified rehabilitation department that opened in April 2012.

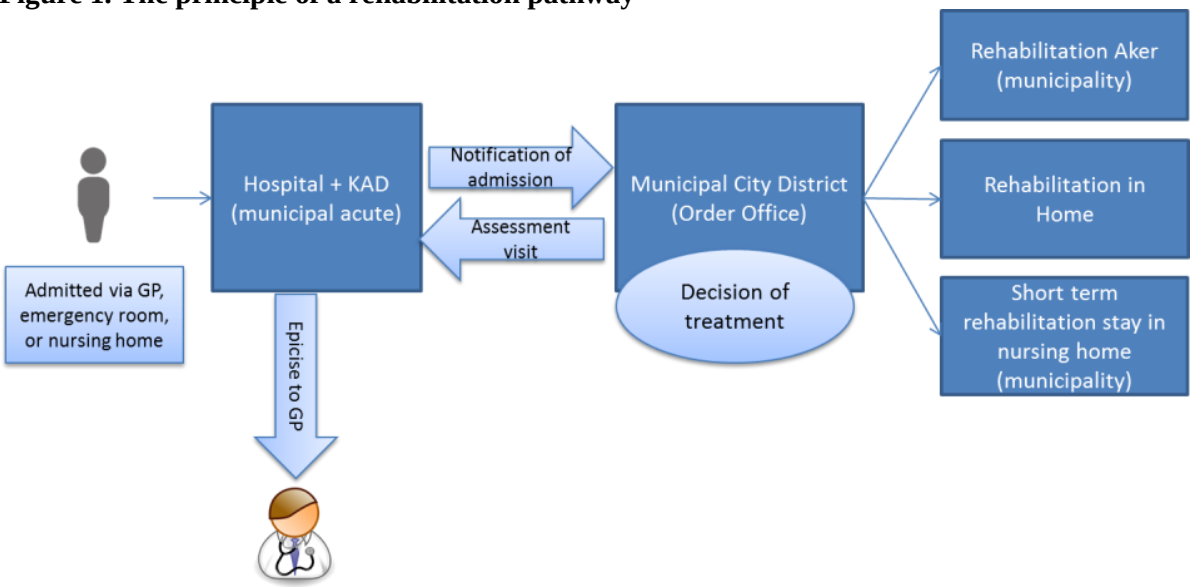
A new rehabilitation unit is introduced

The new municipal rehabilitation department has been located at AHA, and two years after its opening it struggles to find its place within the existing organization of services. The target group for the unit is patients over 60 years that recently experienced function deterioration due to acute illness and in need of multidisciplinary rehabilitation. This can be neurological diseases (cognitive impairment) or orthopedic patients with co-diseases. The unit has 23 beds and about 33 full time staff which represent medical and rehabilitation expertise with a higher professional competence than other rehabilitation offers for this target group in Oslo. Central factors for providing this service is that rehabilitation is both a national and a municipal priority area, and is highlighted in the Coordination Reform (HOD 2009a) as a field where the coordination between the healthcare levels does not work well enough. OK has focus on health and elderly and as a part of this they established the intensive rehabilitation unit at AHA to provide a treatment program at the interface between specialist and primary care. Research shows that intensive rehabilitation after sudden functional loss is critical to retrieve the functionality, and that this is not sufficiently provided at the primary level after the patient is discharged from hospital (Langhammer & Verheyden, 2013). A recent study compared a structured and intensive rehabilitation in an own center, with less structured and less intensive rehabilitation in the short-term residents in nursing homes to measure the efficacy of multidisciplinary day based rehabilitation of elderly in primary care (Johansen et al., 2012). This study shows that older people with disabilities are rehabilitated faster and better in specialized rehabilitation units than in nursing homes, and outcomes are improved and sustained independency of the patients. The findings clearly illustrate that specialized treatment is more cost efficient for the municipalities based on the results of patient’s ability to cope with daily life activities were almost doubled with intensive treatment, hence fewer home services were needed, and the patients spent fewer days as short-term residents in a nursing home after rehabilitation.

Today, almost two years after the opening, the rehabilitation unit is struggling to find a place in the existing rehabilitation practices. In some periods only 50 % of the beds have been in use, even if the need for rehabilitation service is believed to be strong with about 1500 patients that suffer from stroke each year in Oslo. To understand why the units services are not fully used we have looked at the network of actors relating to the unit. As figure 1 illustrates does the rehabilitation pathway expand outside of AHA to nursing homes, GPs, other hospital locations, city districts order offices, and rehabilitation services at home. The

order offices (one office in each of the 15 city districts) have responsibility for the patients in their district, and play a focal role in the patient's pathway by deciding which type of treatment the patients receive provided by the municipality. The order offices are the only actors that have authority to admit patients to rehabilitation at Aker municipal unit. It is in this context we need to understand why the unit's struggles to find its place. Several possible reasons emerge from the observations and interviews with the various organizations involved, and we will focus on three themes that emerged as relevant in the development of the new unit: financial arrangements and organization, collaboration and different views of treatment, and limited autonomy.

Figure 1. The principle of a rehabilitation pathway



Financial arrangements and organization

Financial arrangement is central in the healthcare sector, and who is paying for what has an impact on the activities. In establishing the intensive rehabilitation unit at Aker the cost/price was decided to be the same as for rehabilitation places in nursing homes to ensure that it would not be an issue to decide about the rehabilitation treatment for a patient. However, the way in which city districts order nursing home and rehabilitation places has affected the use of Aker. The order offices are ordering places for one year ahead, with an option to adjust quarterly. In the start-up of the new service at Aker the available places were not filled up, and the unit at Aker thought the lack of use was temporary and would change when the order offices did the quarterly adjustments including Aker in the budget. But this didn't happen. Different explanations are given, and the rigidity of routines for how the places are ordered has been mentioned by several informants:

> 'Districts must purchase nursing and rehabilitation beds, and they have a very tight budget ... so when the need arises that a patient needs to go to Aker and the district did not order it for the quarter, it will lead to extra costs ... The 10 rehab places you have booked somewhere else … So then when the need arises that someone should come at Aker they have not budgeted for it so there's an extra charge.' (Informant # 4)

This is also related to the target patient group at Aker. When a city district buys a bed at Aker, they risk not using it if they don't get any patients in the targeted group. Vice versa, if

the order office has not bought a place at Aker and receives a patient in the target group that would benefit from the intensive treatment, it won't buy it even if there are available beds at Aker because; it would be a cost outside of the budget. The following quote illustrate this point:

> 'It is a pretty fiery prioritization and management responsibilities of the municipality ... We will for example ensure equal treatment and there are many considerations to take. We should not at least maintain an economy of it all. So when tightening really on one area one almost chokes himself'. (Informant # 6)

> 'We are dominated by the town hall budget and patients do not get the services they should have due to the tightening of money'. (Informant # 8)

Several of the respondents mention the way the system is organized as a central cause of inhibiting integration of rehabilitation services, and illustrate the urgency of improving patient pathways called for in the Coordination Reform. The City Council decided to take action to increase the use of Aker rehabilitation in October 2013, when they decided that city districts could buy beds permanently to make sure that all the beds were in use. This resulted in 7 out of 15 districts bought places at Aker. This meant to infringe the principle of providing all citizens with equal access to quality health services. Another consequence was that some patients not in the target group were placed at AHA because the respective city districts already had paid for the bed, and would use it whether the patient where in the specified target group or not. Two specialists working at Aker said:

> 'For example, terminal, psychiatry, somatic + psychiatry. It is not the skills that we have.' (Informant # 9)

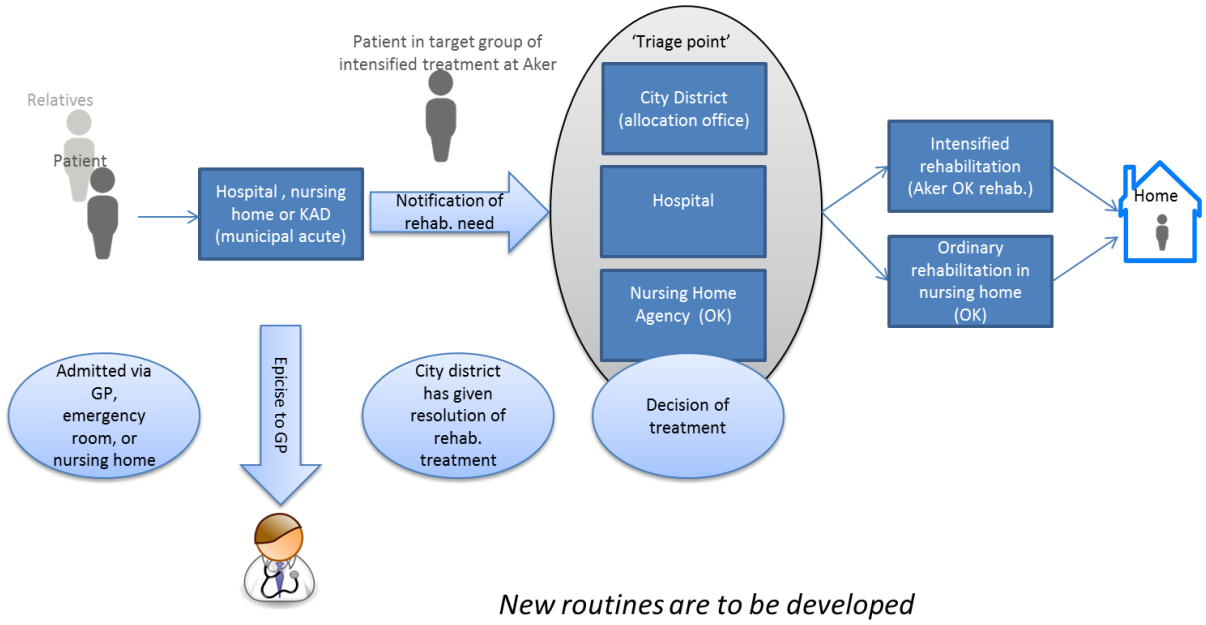
> 'So then we often get a patient admitted for one night before they are going somewhere else, so the city district does not have to pay the price day in hospital... but they're supposed to theoretically relate to our criteria.' (Informant # 5)

The above illustrates how the financial rules of the municipality paying for discharge ready patients affected how the care unit at Aker was used. This is also an illustration of a non-patient-centred system since decisions are taken following budgeting reasoning. The new solution for rehabilitation services did not have the intended effect. Consequently, on February 2014 the City council for Health and Social Services decided to reorganize the unit at Aker to report directly to the Nursing Home Agency (SYE[2]) instead of being organized under another nursing department, and the decisions of some city districts regarding the places were reversed. This was a step to increase the flexibility of the department, and in March 2014 a process was initiated to ensure better utilization of the rehabilitation capacity and expertise at Aker.

Figure 2 illustrates a new process for patients in the target group of Aker rehabilitation. The novel grip in the model is a 'triage point' where the hospital, allocation office in the city district, and SYE meet and decide further treatment in collaboration. One issue raised from the participants was the absence of Aker rehabilitation department in the 'triage point'.

[2] SYE is the acronym of "Sykehjemsetaten" that is the Nursing Home Agency

Figure 2. Proposal of new rehabilitation pathway



The plan is to implement the new model from the 1st of September 2014, and new routines will be developed before then. The new model is developed to account for the financial factors that inhibit the use. However, other possible explanation can be important to understand the whole picture. We will now illustrate how different perspectives and different frames of reference in which decisions are to be made impact collaboration and treatment decisions.

Collaboration and different views of treatment

Hospital staff often mentions the Order office as inhibiting a coherent and effective patient pathway. Several informants have expressed their frustration regarding order offices that are not willing to take their recommendations into account. For example, when a patient is admitted to Aker rehabilitation, OUS discusses the patient case with experts at Aker municipality and agree that the best for the patient would be to continue rehabilitation at Aker intensive unit. Then the hospital informs the order office about this recommendation. It happens (quite often) that the office does not take that recommendation into consideration and the patient does not go to Aker.

> 'We can make recommendations, but yesterday one of my managers got a harsh call from an order office that we must not make recommendations, as it is they who decide' (Informant # 1)

On the other side, the municipal staff expresses their frustration over the hospital who informs patients and relatives of the best treatment without checking with the city district whether the promised service is available:

> 'Sometimes hospitals and rehab at Aker discussed together before the district are contacted, and then the town that gets the blame. Then we got issues if we do not know what Aker rehab was.' (Informant # 10)

> ‘We have the authority to make decisions but not the hospital. The city district does not want the hospital to makes statements until we have considered what we have of offerings’. (Informant # 8)

As previously mentioned, the city districts need to take other factors into account when assessing which service to offer to the patients, while the hospitals do not have any financial responsibility after the patients are transferred to the municipality and can recommend what they think is best without considering the real possibility of receiving that service. The new model implies increased dialogue between the hospital and city districts, but it remains to see how it turns out in practice. But we recognize a political will to enhance this relationship:

> ‘We think that we must begin to open up a bit to get better collaboration and think pathway in wholeness. We must do this together.’ (Informant # 6)

The rehabilitation pathway is not clearly defined and differences in views of what is best treatment are a factor that impacts the actual patient pathway, as described by the following quote:

> ‘We think that when it comes to rehabilitation path it must be made more systematic path where it is described what offers they should get. There are many different degrees of severity of stroke. Some can be trained at home, but some need specialist treatment and rehabilitation inpatient stay. Then it has something to do with funding, and responsibilities between specialist - and municipal health service. But also that we have 15 districts responsible for their population, that determines what services each one should get. If we think of the approximately 1500 that have a stroke a year, then it is clear that not all of them get what they should based on their needs and extent of damage. Because it is not clearly defined path on the type of assistance you should have.’ (Informant # 4)

The following are examples of different opinions of what is best for the patient discussed between a specialist at Aker intensive rehabilitation unit and an order office.

> ‘Aker needs to learn that rehabilitation happens at different levels ... we think that it should be 'good enough'. You must become aware of the city districts situation’. (Informant # 7)

> ‘Hospital says they need rehab Aker, but our assessment that the patient is so well that they can come home ...’ (Informant # 10)

In contrast the expert from Aker meant that rehabilitation at home was not ‘good enough’ when the patient could not walk in stairs and lived at the 4th floor.

Limited autonomy

These contrasting views have also resulted in that some city districts felt that they lost their autonomy when Aker intensive unit kept the patients longer than the city district meant was necessary. Several of the informants mentioned that the new unit at Aker kept the patients longer than the municipalities order offices thought was necessary. This is a consequence of different perspectives on treatment and of how financing impact the different actors. The municipality exemplified that Aker did not listen to them when they said the patient could be sent home:

> ‘We had trouble getting the patient from Aker rehab. We believe that patients should have home rehabilitation. The same doctor who decides when patients go home and say that he should have physical therapy five days a week, but we do not do that. That's part of why we do not buy more seats ...’ (Informant # 7)

This is an example that city districts lose autonomy and also control of the budget, when Aker rehabilitation decide to keep the patient longer. The reason also lies in the fact that Aker rehabilitation doesn’t know well enough which offer the different city districts can offer to the patients at home.

Another example of the Aker department influencing in the city districts perceived responsibility arena is the home care visits. Aker has done their own home visit to create insight and understanding of the patient’s functionalities level at home. This has been perceived as an interfering with the city districts responsibility.

Finally, how the order offices are used to exercise their responsibility is another possible impacting factor.

> ‘… it's probably a tradition that districts want to use the nursing homes in their neighbourhood… And patients want the as well, they want to their neighbourhood. … Also they may be more concerned with geographic location than the service.’ (Informant # 4)

This impression was confirmed by one of the informants, but it was made clear that also the offer was of good quality.

> ‘12 min to go for us. So more convenient to get there than Aker’ (Informant # 7)
> ‘They have to change some of the mindset on how they plan and that takes time’ (Informant # 2)

DISCUSSION

There are several aspect of the case that contribute to explaining why the new unit (partially) fails to be used by other actors in the relevant healthcare network, despite the clear demand for the rehabilitation services in Oslo municipality and despite the relatively high quality of the rehabilitation services it is offering. In the story of the new Rehabilitation unit at AHA it is evident that various actors involved offer different ad hoc explanations for the limited use of the new unit despite it is offering high quality rehabilitation services for which there seems to be clear demand. The case points to an explanation that can help to support more effectively innovation in healthcare.

The two main reasons behind setting up the new unit, in line with the spirit of the national Coordination Reform, appear convincing at face value. The unit is charged with offering rehabilitation services more specialized than rehabilitation services generally offered by other units in the existing healthcare service network. Also the second motivation that the new rehabilitation unit should be experimenting with and developing the “best pathway” for rehabilitation care to be offered to rehabilitation patients appears worthy to pursue. At first sight both aspects seem reflected in the creation of the new unit. The problem appears to be that the two aspects are not felt as particularly urgent by other healthcare actors such as the ‘order offices’ and administration of the primary care. There appear to be some controversies about what is best pathway of care for the elderly rehabilitation patients. The local offices

appear to send the patients to rehabilitation services available nearby or at home rather than directing them to the specialized unit, claiming to understand well the needs of the patients and the best pathway. The reasons for the limited use of the new services unit provided by some of the order offices are an example of the intangible nature of factors that explain the "resistance" to integrating the new service in the existing system. The argument of policy makers promoting the new rehabilitation service unit that the novel offering responds to the 'needs' of patients and their users is in contrast with the arguments for keeping patients closer to their homes and familiar environments by using rehabilitations services at nursing homes or from home based services.

Also the existing budgeting and compensation rules appear to favor using more local (close) rehabilitation services in various city districts by imposing capacity planning and ordering forehand. Attempts of the policy makers to ease the compensation rules in relation to the order offices and to facilitate using the new service have not produced intended effect. Despite the strong actual demand for rehabilitation of the target group of patients, only few of the municipal order offices allocate patients to the rehabilitation unit at AHA because the existing financial arrangements do not favor use of the new unit service. Also the tightening economy means the primary care preference to use beds (and services) that have been booked well beforehand. Practices of order offices in the city districts made the Oslo municipality to look for a better system for how places at Aker were ordered and funded and three times during the first two years there have been changes in that.

For the order offices and the patients the new unit represents a change in the current practices of rehabilitation and allocation of the patients to various service units. In this transition phase, both the order offices and other service units tend to continue doing as they were used to do. Even if the Coordination Reform is aiming to move tasks from hospitals to the municipalities and aims at strengthening the position of the primary care, it does not provide sufficient incentives for inducing the change. While the new unit's offering is struggling to find its place in an establish chain of services some city districts are using it more than others, and it is interesting to follow and investigate why. There are some indications of 'controversy' between institutionalized practices in the municipalities and the aims of the national Coordination Reform. The intended change and following actions at the institutional level are affecting the current practices, but not necessarily in the intended direction.

Contrary to what one would expect in regulated sector like healthcare, policy actors in this case did not play an active role in promoting that solutions be taken locally and be negotiated directly among the actors involved. However, in a context of the Norwegian healthcare sector, characterized by a strong division of roles and competences between primary and secondary care, it seems that actors have difficulty in findings a common ground in conversations; they apparently ascribe rather different meaning to the quality of care offered by rehabilitation services. This is in line with Hanssen, Helgesen, and Holmen (2014) who discusses how the Coordination Reform provides for a change towards a more egalitarian, negotiated and partnership based relationship between the state (hospital) and municipality. They conclude, among other things, the importance of administrative leadership, as negotiator, able to bridge the gap between municipal and health authorities. This is important to achieve a vertical integration.

CONCLUSIONS

It is evident that the traditional linear view of the innovation processes that links the acceptance of the innovation to the superiority of the solution is thus not of much help here.

Different interpretations by different actors of the reasons for establishing the new rehabilitation unit and about what it actually offers. The lack of a common/collective meaning of the new solution appears as a major factor in explaining why, despite serious attempts to embed the new service in to existing network of rehabilitation activities, it remains underemployed and plays a marginal role compared to the intended one. Focusing on the economic and instrumental aspects of innovation, apparently fails to explain why the new unit offering which is superior to others existing in the municipality – more specialized and with superior competences – and responds to an existing real demand, is not accepted and used by neither other healthcare actors (e.g. order offices) nor the final users.

The story of the Rehabilitation unit at AHA confirms the critical role of the social and political dimension in explaining the outcomes of the innovation process. In our case the various actors concerned with the novel organizational solution have difficulty in finding a common ground in reciprocal conversations. For instance, they clearly ascribe different meaning to the care services offered by the new rehabilitation unit. Looking at the social and political dimension of the innovation process we can see that the process is contingent on making sense of the new solution among the various actors involved as the innovation in practice involves developing and changing the modes of relating (La Rocca & Snehota, 2014). The case of Rehabilitation unit at AHA suggests that it is critical for accepting an innovation is that various actors concerned with the process share a way to make-sense of the new solution introduced and its consequences.

Acceptance of an innovation, in particular in the case of new service organization, appears thus contingent on a process of constructing a collective meaning of the novel solution. Acceptance of an innovation is related to the meaning of the innovation for the involved and in particular to the perception of the consequences the novel solution has for those who take part and are concerned with the process. That means that parties involved have to negotiate the meaning of innovation in their inter-organizational encounters, and in turn implies the need for major attention to the communication processes and to the construction of image and identities among the different actors that concur in the innovation process.

Given the multiplicity of actors involved in innovation processes in general and in particular in the healthcare sector and the lack of a superior authority, the awareness, among the policy makers, of the need to create a collective meaning is a condition for effectively sustaining innovation in service context in general and in the healthcare services in particular. The research on how collective meanings emerge in relation to the innovation processes is relatively limited but the topic appears to deserve further research.

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