Coordination of Health and Social Care Services between Primary and Secondary health and social care institutions in the Eastern Regional Health Enterprise (RHE)

The coordination challenges and problems in the mental health and social care sector for long term mental patients

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Master Thesis submitted for the degree in Health Economics, Policy, and Management

UNIVERSITY OF OSLO

15 May 2007

Abstract

The objective of my research study is to find the problems and challenges of coordinating health and social care services for chronic or long term mental care patients. And what can be done to alleviate the problems and challenges of coordinating health and social care services in the mental health care sector, and their effects on the patients. My research study, applies to the mental care patients with individual patient plan, and who receive health and social care services from both primary and secondary health care organizations.

The research study concentrated in the counties and municipalities of Akerhus and Oslo, which is a part of the Eastern Regional Health Enterprise. My research study employed the Qualitative Research Methods, using In-dept Interviews to find out the problems and challenges of coordinating health and social care services for the mental care patients. During the interviews process, I had conducted interviews with the representatives of the following institutions:

- The Directorate of Health and Social Affairs (DHSA)
- Primary Health and Social Care Services (PHSCO)
- The Secondary Health and Social Care Services (SHSCO)

My interviewees are the top, medium and low level managers from the above mentioned health and social care institutions.

My research study revealed that the problems and the challenges of coordinating health and social care services in the mental health care sector, is caused by and among others, the problem of coordinating and implementing the national health and social policies. These include individual patient plan act, earmarked state grants and cooperation agreement between primary and secondary health care organizations. There are also the problems of organizations, structures routines, information and communication in both primary and secondary health care institutions, resulting to fragemented sector and divisions, which cause intra/inter-organizational challenges of coordinating health and social care services. The under funding of mental health care sector is causing capacity and competence problems in the mental health care organizations, which is affecting the continuity and holistic delivery of health and social care services, and thereby, affecting patients chances for recovery and rehabilitation in their communities.

Aknowledgement

My thanks go to all the organizations and individuals that provided valuable information and support during the course of my research project. My sincere thank goes to my supervisor Professor Ole Berg, who tirelessly and patiently worked with me since the start of my master program. His useful instruction, guidance, comment and encouragement gave me a lot of motivation, and has greatly improved the quality of my study. My appreciation goes to Norwegian Health Research Organization (HORN) for giving me the financial support that facilitated a lot of my research work. My gratitude goes to the Institute of Health Economic, Health Management and Health Policy at the Faculty of Medicine, University of Oslo in Norway for giving me the opportunity and guidance to achieve my goal and ambition for attaining this higher level of education.

My profound thank goes to all my informants for taking off their useful times and for providing me with all the necessary information for this research study, my sincere gratitude goes to Directorate of Health and Social Affairs, the Norwegian Board of Health, Aker University Teaching Hospital, Akerhus University Teaching Hospital, Ullevaal University Teaching Hospital, Alna Municipal Authority, Follo District Psychiatric Centre, Ensjø and Southern Nordstrand Municipal authorities for giving my informants permission and time to have interviews with me.

I would like to thank all the academic and administrative staff at the Institute for having come in contact with them for advice, information or technical assistance and not forgetting my fellow students at the Institute of Health Economic, Health Management and Health Policy for exchanging views and ideas, and for having good times together at the Institute for the last two years. My special thank goes to my parent for bringing me up and for educating me, and my heartfelt gratitude to my Dear Wife and our two beloved children. The glory and praise be to the lord God for giving me and my family good health, knowledge and understanding. I will leave the Institute of health economic, management and policy with full appreciation, for having equipped me with knowledge and expertise that I am taking with me home and try my luck out there. May almighty God bless all of us.

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Abbreviations

AHUS: Akerhus University Hospital
AUS: Aker University Hospital
CHSCS: Coordination of Health and Social Care Services
DHSA: Directorate of Health and Social Affairs
DPC: District Psychiatric Center
HORN: Health Research Organization in Norway
IPP: Individual Patient Plan
LEON: Lowest Effective Health Care Level
LPP: Mental Patients Organization
NBH: Norwegian Board of Health
NOU: Norwegian Bureau for Public Documentation analysis
PHSCO: Primary Health and Social Care Organization
PHSCS: Primary Health and Social Care Services
RHE: Regional Health Enterprise
SHSCO: Secondary Health and Social Care Organization
SHSCS: Secondary Health and Social Care Services
SSB: Statistics Central Bureau in Norway
St. meld: Norway`s Parliamentary report or commission
UUS: Ulleval University Hospital

Working Definitions

Accountability: The responsibility for actions or decisions.
Authority: A source of power in organizations which is formally sanctioned, often expressed by role or position of an individual within the organizational hierarchy.
Bureaucratic organization*:* An organization structured on democratic principles with clear roles, lines of authority and accountability, procedures, rules, and policies for how work is performed and several levels in hierarchy.
Bureaucratic Theory: Classical bureaucratic theory
Centralization and Decentralization: Centralization occurs when decision making is concentrated at the top of the organization. Decentralization occurs when decision making is delegated or decentralized to lower levels in the organization.
Clinical Guidelines or protocols*:* Standardize the decision process for adopting treatment approach, it address the appropriateness of care by specifying the indication for either test or treatment.
Clinical Pathways standardize the treatment approach for a given clinical condition.
Clinical Mentality: The cognitive frame of clinicians for examples physicians and nurses which was developed through professional education and experience.
Communication: The creation or exchange of understanding between sender(s) and receiver(s). Effective communication plays important role in both programming and feedback coordination mechanisms.
Competition: Parallel striving by multiple parties toward a goal that all parties cannot reach at the same time.
Coordinating Mechanisms: Mechanisms for managing interconnectedness of work.

Coordination: A mean of dealing with interdependencies by effectively linking together the various parts of an organization, or by linking together two or more organizations pursuing a common goal.

Coordinator Role: A role assign to a team member, with defined responsibilities for coordinating other team members who are serving the same patient.

Critical Pathways or Clinical Pathways: are plans for managing patient care that display goals for patients and provide the corresponding ideal sequence and timing of staff actions to achieve those goals with optimal efficiency. Thus for a given diagnosis or condition, a critical pathway specifies the work activities in advance.

Decision Making: Is a process by which teams attempt to apply all available information to the problem at hand so as to make correct decisions.

Effectiveness: In organization is the degree to which organizational goals and objectives are successfully met.

Efficiency: Is defined as the cost per unit output.

Feedback Approaches to Coordination: Managing interconnections among tasks through interaction and communication among those who perform those tasks.

Health Care Management: Is a process of tailoring services to individual needs. Assessment is an integral part of care management.

Health Care Manager Role: A role with responsibilities for accessing, coordinating and liaising with all the services a client or patient need for his or her assessment, treatment and care.

Health system: Is an arrangement among hospitals, physicians and other health care provider organizations that involve direct ownership of assets on the part of parent system.

Institution: An organization built to help people with special needs e.g. the sick, old and disable persons.

Integration: Structures and processes that tie the various units of an organization together so as to increase coordination and collaboration

Integrator or coordinator: Is individual who because of specialize knowledge and because they represent a central source of information, are able to facilitate coordination for example physicians and nurses.

Interdependence: The condition of mutual dependence between organizational units or entire organizations that exist whenever work activities are interconnected in some ways.

Leadership: Providing direction in group activities and influencing others to achieve common goal.

Leadership role: One of the role of a manager, which intentionally influencing individuals and groups in order to accomplish a goal.

LEON- Principles: The provision of health care services at the lowest economic cost effective level of the health care organizations.

Linking pins: People who serve formally as links between various units in the organization.

Model: A model is a simplified representation of a real world or fact.

Multidisciplinary Team: A small group of people, usually from different professions and agencies, who meet regularly to coordinate their work providing services to one or more clients in a defined area.

Organization Structure: The appointment of responsibility and authority among members of an organization.
Organization Theory: Is systematic examination of the ways that organizations function.
Politics: Domain of activity in which participants attempt to influence organizational decisions and activities in ways that are not sanctioned by either the formal authority system of the organization, its accepted ideology or certified expertise.
Professional Manager: Management head of a single-profession such as physicians and nurses.
Reciprocal Interdependence: Occur when individuals and units bears close relationship, such that they mutually depend on each other to achieve given tasks.
Rehabilitation: Restoring some one to a normal life by retraining and medical treatment after illnesses.
Sequential Interdependence: Occurs when one person or unit depends on another for resources or information to accomplish a task.
Standardization of Work Processes: A way of coordinating work that program or specifies work. Health care organizations standardize work processes when possible, such as standard admission and discharge procedures or standard methods of performing laboratory tests.
Strategy: An integrating set of ideas and concepts that guide an organization in it attempt to achieve it goals and objectives.
Uncertainty: Inability of an organizations or managers to accurately predict the consequences of an action or the future state of an organization and its environment.

Chapter 1: Introduction

1.0 Introduction

My introduction started by defining one by one the key words of the research theme, I wanted to leave no doubts in the minds of my readers, what the key words represent individually and collectively in the context of my research problems.

Coordinate: to bring into order as part of a whole, equal in rank and importance, etc.
Collaborate: to labour together, to act jointly.
Cooperate: to act jointly with another, to work for a common effort.
Health: condition of a person`s body or mind, state of being well and free from physical and mental illness.
Social: especial attribute concerning the organization of and relations between people and communities, social welfare or reforms.
Care: is giving understanding and practical help, and curing removing the causes of disorder.
Services: performing duties in working for a government or a company, health and social care services.
C.H.S.C.S: Coordination of Health and Social Care Services
The role and function of coordination system in health care organizations is like the role and function of blood vessels in blood circulatory system in human bodies.

Coordination is about how people from different organizations, agencies and professions work together to meet the health and social needs of people in a community. It is about making the most of different skills to meet people`s health and social needs by acting jointly for a common goal (John Øvretveit, 1993). This is because when we have health and social needs, it is rare that one profession alone is able to meet all of our needs, we benefit most from the skills and knowledge of different specialists acting separately for a common effort, so long as their help is well coordinated. This is the central essence of coordination of health and social care services. However for a patient to benefit most from the helps of the different specialists, their help must be well coordinated. More often these specialists are employed by more than one agency, making coordination of health and social services even more challenging. Because of their attachment to the employer and their trade unions or professional associations, as such, we see the consequences of failures of coordination every day by patients complain, in law court and by the frustration of patients and health care specialists. The causes of failed coordination are many and well documented. They include fragmented and unclear responsibility, failure to act or negligence of duty, lack of capacity, resources and competence that have caused pain, suffering, misery and frustration to untold number of patients and their relatives.

1.1Research Questions

How are the health and social care services for chronically ill mental health care patients coordinated between primary and secondary health and social care institutions in Norway? What are the coordinating problems and challenges faced by these institutions?

How do the challenges affect the individual mental care patients, their relatives and hence the society? And how can primary and secondary health and social care institutions overcome the challenges?

The main task and challenges to my research study is to find accurate and credible and convincing answers to my research questions. In finding the answers to the challenges in coordinating health and social care services to my patient group, I turn to the Directorate of Health and Social Affairs (DHSA), the central authority for health and social affairs in Norway, to the Regional Health Enterprises (RHE), and finally to the primary health and social care institutions in the counties and municipalities. The first institution has the over-all responsibility also for the entire system of psychiatric care in the country, while the second and third types of institutions are responsible for providing the specialized and more primary care

After having identified the Directorate of Health and Social Affairs, the Primary and Secondary Health and Social Care Services as my main informants on health and social care policies and professional management, provision of both specialist and primary health and social care services by asking them individually specific questions concerning their roles and responsibilities in the provision of holistic and coordinated health and social care services to the chronic mental health care patients.

1.2Research Objectives

The objectives for writing the master`s thesis is first and fore most to complete my two years masters study program in International Master in Health Economics, Health Management and Health Policy at the faculty of medicine, Institute of health economic and health management at the University of Oslo. And the objectives for writing the master`s thesis on the coordination of health and social care services are the following:

- It enables me to learn more in-depth about the structures and organization of health and social care services in Norway. How health and social care organizations functions, cooperate and coordinate their activities to long term mental health care patients. Mental health or psychiatric disorders involve disturbances in thinking, emotional state and behaviour. These disorders are caused by complex interactions between physical, psychological, social, cultural and hereditary influences (The Merck Manual Medical Information, 1997).
- It enables me to learn more about the practical implementation of national health policy for mental health care, particularly difficulties with implementing the policy of holistic and coordinated health and social care services to individual patients. The aims of this project is to uncover the problems connected with implementation of this policy and find solutions that may improve the living conditions and quality of life for mental patients, and this research will focus on these patients group which is in itself good for the patients group and also good for the society.
- It increases awareness and more understanding of problem in mental health sector and the importance and role play by good or bad coordination. Knowledge and experiences gain from this project may also give premises for new projects.

1.3Motivation for my research my research study

Mental health illness or psychiatric disorders is a major public health problem throughout the world. It affects both children and adults. Research carried out in Norway shows that one third of the Norwegian population in one way or the other will experience mental problems in the course of their lives. It was revealed in this study that 20% already had experienced mental disorders during the past few years. It was also found that at any given points in time between 1% and 1.5% of the population is suffering from a serious mental disorder like chizophrenia, that 4 out of 10 patients which consult GPs have mental problem and mental disorder is the main reason for disability in Norway.

Besides the study of coordination challenges in mental health and social care services between primary and secondary sector, I have taken interest in finding more about schizophrenia, because of its outstanding costs and effects on the patients and the society. The tragedy of this single disease diagnosis group has both national and international dimensions. This is specific reason for choosing schizophrenia as one of my research study elements. Schizophrenia is a serious mental disorder characterized by loss of contact with reality (psychosis), hallucinations, delusion (false beliefs), abnormal thinking, disrupted work and social functioning. Schizophrenia is a major public health problem throughout the world. The prevalence of Schizophrenia world wide appears to be slightly less than 1 percent, although pocket of higher or lower prevalence have been identified. For example in United States of America, people with Schizophrenia occupy about 25 percent of all hospital beds and account for about 20 percent of all Social Security disability days. In United States Schizophrenia is more prevalent than Alzheimer`s disease, diabetes or multiple sclerosis (Robert Berkow, M.D The Merck Manual, Home edition).

While the prevalence of Schizophrenia in Norway is about 3-5 per 100 persons, and the incidence is about 7-15 per 1000 population. The yearly expenditure connected with Schizophrenia is estimated to be 4 billion Norwegian kroners. The research findings show that Schizophrenia cost the Norwegian society more than all heart diseases, all cancer diseases and all rheumatism diseases respectively. This cost is connected with the fact that the sickness starts early in life and that 25% of all the affected persons become chronically sick. (Sosial- og helsedirektoratet, tema: Samarbeid første- og annenlinjetjenesten (Jon Magnussen, SINTEF- Helse: Prioriteringsproblemer knyttet til pasienter i gråsonen mellom 1. og 2. linjetjenesten)). My research study revealed that schizophrenia is the single largest mental disorder disease in Norway. In this connection, Schizophrenia as a disease have both national and international dimensions, partly because of its magnitude, costs and effects on patients and for society, and therefore, this justifies my reasons for choosing this research object.

1.4The Norwegian Health and Social Care System

The national health and social care services are organized into two sectors, Primary Health and Social Care Services (PHSCS) and Secondary Health and Social Care Services (SHSCS), which is referred to as the first and the second lines of health and social care services. The two sectors formed the national health and social care systems, constituting both somatic and psychiatric health care services and the two sectors operate

as two levels of health and social care organizations. The two organizations operate as independent and separate legal entity. However the two organizations are connected by National health policy, Health and social care policy of continuity, holistic and coordinated health and social care services for chronically sick or long term care patients, who receive health care services across the two levels of health and social care organizations. In the mental health care sectors, this national health policy is called Individual Patient Plan (IPP). The two health and social care organizations is further connected by sharing common patients populations, and by mutual dependence on each other for sharing goal for patient and common information on patients when crossing from one level of the organization to another, which is necessary for the coordination and continuity of health care services without a gap in between the two sectors. The state is responsible for financing the secondary health care whereas, primary health care is financed by the municipal authorities and supplemented by earmarked state support. PHSCS operates as ordinary health and social care institutions, while the hospitals shall operate and manage as business like enterprises. The mental health care organizations have adopted a flat and integrated organization model which aimed at facilitating patients flow logistics, coordination and communication internally within the hospital settings and externally in dealing with primary health and social care sector, National health authorities, patient organizations and other health care organizations.

1.5Mental Health Care plan

The mental health care plan is also known as the Individual Patient Plan (IPP), and according to this plan the person with long term and coordinated health and social care needs from both the primary and specialist health care services have rights to an individual plan. The individual patient plan shall include all health and social care services like education, social security and labour. The patients or users as they are called in the mental health care sector, will ensure genuine user influence in the individual plan processes. The plan will describe concrete health and social care needs for the user and how the health and social care needs shall be achieved. The patient plan includes medical treatment plan, social care plan, learning plan and user handling plan and the responsibility for individual patient plan lies in the hands of both primary and secondary health and social care organizations.

1.6 The challenges and problems of coordination

The challenges of coordination in mental health care is the fact that patient are unable to follow up their health and social needs, because of the nature of the mental illnesses that make them unable to take care of their health and social needs and depend on the help of other to do this for them. The Norwegian national mental health care program required the complete and coordinated health and social care services to chronically ill mental care patients who receive health care services across the two levels of health and social care organization. It gives patients rights to influence decisions in health care services that affect their live. Individual Patient Plan (IPP) is a health and social care policy coordinating mechanism. My research finding reveal a number of challenges and problems in coordinating mental care services, this include fragmented services due to poor coordination, under-funding, organization and structure, leadership and

management, communication and information systems, capacity and competency to mention a few.

1.6.1 The Challenges of Coordination

The challenges to coordinating health and social care for mental health care patients are further complicated by the fact that the health care services involves of diverse professional groups, employed by different organizations and agencies, and have their loyalty to their professional organizations. And yet coordinated health care services require multidisciplinary teamwork, which is working together in a common effort to save the interest of a patient. This complexity offer serious challenges to coordinating comprehensive health and social care services to a single helpless patient who depends on the help that he or she can get from the health care personnel. Failure to receive the needed help, and not knowing who offers what and where it come from, besides incomplete discharge information, wrong references, wrong diagnosis, failed contact etc. These challenges and difficulties are faced by both the patients and health care workers in their daily interaction and duties. These are the challenges my research questions set to identified, find their causes, how it affect the patients, is the authority aware of the problems and what they are doing about it and my personal views on the challenges.

1.6.2 The Problems of Coordination

The organization structure of health and social care institutions, the physical location between departments, divisions and units are located far from each other. Offering coordination and communication challenge between various departments, divisions and units. Inside the hospital settings, the complexity in clinical processes, procedural and routine, variation in long and short clinical pathways, patient logistics and supply challenges, complex coordination system and communication network. The resource and economic problems, skilled personnel, capacity and time factors for doing satisfactory clinical routine work, the external coordination and communication problems in dealing with various primary health and social care organizations, patient support organization and the central authorities at various levels. Besides technical system problems, inappropriate referrals by GPs, physicians and other health care professionals, self-referrals by patients who have little faith in any thing but hospital care, overworked primary and secondary health and social care workers, inappropriate referrals by inappropriate or misguided hospital treatment, or by the provision of inadequate referral or discharge information. All these can upset the coordination of holistic and coordinated health and social care services for long term health care patints(L.H.W.Paine & F. Siem Tjam, 1988).

1.7 Research methodology

Research method: Qualitative, in-depth interviews, using structured and unstructured interview.

In searching for the answers or the results of the above questions, I will use qualitative research method. I will use qualitative method for collecting research data, and analyzed the collected data to document the empirical evidence. I will use both primary and secondary data to find answers to my research questions, and started the research process by making contacts with the below institutions and ask for formal interviews with them one by one. Started from the Directorate of Health and Social Affairs (DHSA), as

representative of central authority in health and social affairs, Primary and Secondary health and social care institutions in Oslo and Akerhus counties, the details of the institutions contacted and personnel interviewed can be found in the below tables.

Chapter 2: Theoretical and Conceptual Framework

2.0 Theory of organizational bureaucracy

After having gone through my literature reviews, and after having read a number of theories and theoretical perspectives, with the aim of finding a theory that can best address my main research questions. However I did not find any single theory that could address all issues raised in my research questions. However, after careful consideration of a number of possible theories that could best answer my research question. I came to a conclusion that the theory of bureaucracy, its perspectives and mechanisms is best suited among the alternatives to answer my research problems. I will come back to the appropriateness and deviation of this theory from answering all of my research problems. Which is the problem of intra-organization and inter-organization problems of coordination, and I found this problem rooted in the organization theory of bureaucracy.

Health and Social Care organization is a professional organization, with a top to down bureaucratic structure. This type of organization hinges on the fine line between collegiality (working for the common good) and politics (working for self-interest). It need professional organizations to carry out highly skilled yet highly stable tasks in society, such as replacing someone`s heart or auditing a company`s books. But as a society, we should learn how to control their excesses, like professional who mistreat /their clients or professional organizations that mistreat their supporters. It is therefore important for people to understand how these organizations work and function. I find the theory of organizational bureaucracy best suited for describing the unique structure, internal processes and context of configuration of health and social care organization.

An organization as described above can be bureaucratic without being centralized. This happens when its work is complex, requiring that it be carried out and controlled by professionals, and yet at the same time remains stable, so that the skills of those professionals can be perfected through standardized operating programs. The structure takes on the form of professional bureaucracy, which is common in universities, general hospitals and social work agencies, and firms doing fairly routine engineering or craft work. All rely on the skills and knowledge of their operating professionals to function, and all produce standardized products or services. To understand how the professional organization functions at the operating level, it is important to understand the standardized working program, repertoire of skills the professionals stand ready to use that applied to a known situations, called contingencies. This process is known as pigeonholing. In this regards, the professional has two tasks, one is to categorize or diagnose the client`s need in terms of one of the contingencies, which indicates which standard program to apply, and another is to apply or execute that program. The pigeonholing process simplified work organization and structure, and it enables each professional to work in relatively autonomous manner. In professional organization, diagnosis is a fundamental task, but one highly circumscribed. The organization seeks to match the predetermined contingencies to a standardized program. It is a fully open-ended diagnosis that seeks a creative solution to a unique problem.

The relationships between Mintzberg`s theory of organizational bureaucracy and the hybrid professional bureaucracy that developed from the bottom by the professional themselves in the course of their long practices and tradition in the field like the iatrocratic health care organization in Norway which was developed by medical professionals by themselves, not imposed from the above by the bureaucrats or politician from the above. But rather internalized the rules and regulations that come from above in hierarchical order by accommodating or integrating into their systems as clinical guidelines, direction or protocol. Therefore this relationship requires further clarification.

The bureaucracy is hierarchically organized. The hierarchy is much formalized. The bureaucracy is functioning on the basis of laws or regulations. Bureaucrats are applying laws to concrete cases. They are in many ways functioning like judges. Thus, they are also functioning in a strictly impersonal manner. They are, like the impartial judge, blindfolded. While an organization dominated by a profession, like medicine, is not, strictly speaking functioning on the basis of rules or laws given from above, but on the basis of knowledge that to some extent may be formalized and made into what resembles laws, procedures. But these procedures are technical rules, and requires, for their implementation knowledge of the principles underlying them and in general of the body to which they employ. They are developed, not by "alien" superiors, e.g. legislators, but by the professionals themselves or the researchers among them. Hence, the procedures come from below, or from within, and not from above and outside. So even if there may be a sort of hierarchy within the profession, the professionals as such, and as care providers or producers are not subjected to the authority of others who are not doctors. But something also comes from above in say a hospital: some ordinary laws and rules, and perhaps a budget. This, which comes from above, is to some extent applied in a bureaucratic way. A hospital, then, often represents an uneasy compromise between a bureaucratic and a "professiocratic" or "iatrocratic" regime. However, there is an obvious tensions between bureaucrats and doctors in hospitals. The medical professional resist the bureaucratic rules which come from the above to challenge the iatrocratic regime that developed from within of from bottom through long tradition or practices (Ole Berg, 2005).

2.1 Development and trend in Norwegian health care organization

The health care organization and policy in Norway was and still shape by history, culture and norms of the Norwegian society. Hospital as social institution was initiated and developed by individual craft men in the society. It all started as a one man practice place for a doctor, and later doctors were aided by one or two nurses. These individual doctors practice led to the development of a hospital as a small workshop for the doctors, with a simple organization structure. This small organization was organized and ran by a doctor, dentist or pharmacist.. Clinical mentality developed from the practical mentality of doctors who want self autonomy. Hospital organization emerged from below through the private practices of doctors, it was not formed by political organization. As hospitals developed and grew into the iatrocratic structure with semi-independent departments headed by chief physicians. The principle and logic underlying this kind of hospital organization is called an Iatrocracy regime (Ole Berg, 2006).

This practice based physicians and later dentists organizations functioned on fairly iatrocratic premises, whether inside or outside the public sphere. This development set the trend for the organization and management of health and social care services in Norway. From the private practices of individual physicians developed hospital organization, later nationalized and funded by public. The bureaucratic iatrocracies were mildly controlled and managed from above, but clinical management, control and responsibility was left in the hands of professional managers (chief physician). The iatrocratic nature of health care organization poses a great challenge for the Norwegian health authority to introduce a radical reform in health care organization, not least challenges for the coordination of health and social care services, because of multidisciplinary nature of health and social care professionals, however, despite the resistance from the medical professionals, The story in Norway, as elsewhere is a story about the growing bureaucratic "attack" on the professiocracy, or iatrocracy. Generally the trend is that the hospital is becoming more of a bureaucracy and also a business enterprise and less of a iatrocracy. The balance between the two "regime elements" is tilting in the direction of the bureaucracy (Ole Berg, 2006).

2.2 Perspective on organizational coordination problems

Professional organization is viewed as collections of independent individuals who come together only to draw a common resources and support services. Though pigeonholing process facilitates coordination, some things inevitably fall through cracks between the pigeonholes. But the professional organization lacks any obvious coordinating mechanism to deal with these problem, they inevitably provoke a great deal of conflict and uncertainty. Much political blood is spilled in the continual reassessment of contingencies and programs that are either imperfectly conceived or artificially distinguished (HM). To manage conflict in the process and solve problem of decision making and accountability in the system, organization employ mechanisms for managing the interconnectedness of work by means of coordination. And coordination is a mean of dealing with interconnectedness by effectively linking together the various parts of an organization or by linking together two or more organization pursuing a common goal. This conscious activity is aimed at achieving unity and harmony effort in pursuit of shared objectives within an organization or among organizations participating in a multi-organizational arrangement of some kind (Beaufourt B. Longest).

To suit the analysis of my research study, I will narrow down Henry Mintzberg`s theory of organization bureaucracy to the problem of coordination also known as interorganization and intraorganization problem of coordination. This can best be illustrated by defining Mintzbergs five mechanisms of coordination: Mutual adjustment, Direct supervision, Standardization of work process, here Critical pathway and Clinical guide lines or protocol are important, Standardization of work output, Standardization of worker skills and by looking at contingency view of coordination, where task uncertainty and interdependency are the key concepts. Putting this description into perspective, I proceed with my study analysis by focusing, especially on intraorganization and interorganizational program or contingency work processes by looking at patient critical pathways, that I refer to my study as patient pathways to suit my study of health and social care organization, that is the main theme of my study. The patient pathway is a

model I use to analyse the problem of coordination in the Norwegian health and social care organizations.

As health care organization is characterised by complexity work processes, programming and feedback, programming approaches to coordination seeks to clarify work responsibilities and activities in advance of the performance of work, as well as to specify output of work process and the skills required. Programming approaches standardized work activities for all expected requirements. While feedback approaches to coordination entail by contrast, the exchange of information among the staff, usually while the work is being carried out. These approaches permit staff to change or modify work activities in response to unexpected requirements and rely extensively on effective communication (March and Simon 1958).

The approaches to standardizing the process and outputs of patient care activities is the use of Critical pathways, critical pathways, also known in health care circles as clinical pathways, care map, and critical paths. Originated in the manufacturing sector, where they were used for identifying and managing steps in production processes, and applied to health care settings, critical pathways are management plans that display goals for patients and provide the corresponding ideal sequence and timing of staff actions to achieve those goals with optimal efficiency (Pearson, G.Fisher, & Lee, 1995). Thus for a given diagnosis or a condition, a critical pathways specifies the work activities in advance. Another important tool being used to standardize patient care process is Clinical guidelines or Protocol. This tool addresses the appropriateness of care by specifying the indications for either tests or treatments. Whereas critical pathways standardize the treatment approach for a given clinical condition, clinical guidelines standardize the decision process for adopting a treatment approach (Pearson et al, 1995).

Most health care organization have the mechanism or mechanisms for coordination in place, according to contingency view, no single approach to coordination is best for all situations. According to contingency approach, coordination requires that managers match the most appropriate coordinating mechanism or mechanisms to a given situation (Mintzberg). In addition to organization structure and coordinating mechanisms, organization can also establish position of integrators or linking pins to facilitate coordination. However, success of integrator depends more on having professional competence and specialise knowledge than occupying a particular formal position. In patient care integrators provide important coordination among various departments and sub-units, in health care organizations physicians or nurses function as integrator, regardless of their formal positions (Lawrence&Lorsh, 1967).

Thus the bureaucracy and the professiocracy relates to each other by the fact that the bureaucratic is related to hierarchic coordination, especially rule oriented hierarchic coordination. The development and application of evidence based procedures is the application of Mintzberg`s concept of professional bureaucrats or iatrocratic organization in health care institutions in Norway. These procedures make possible an increasing industrialization of health care services. The iatrocratic form of coordination is both related to feedback-based coordination and co-ordination based on traditions, routines

etc., developed by medical men. The development of procedures takes place within medicine, and is a continuation of the practice of local rules, methods books, and routines coordination. Thus, this form of iatrocratic coordination to some extent turns iatrocratic coordination into something that is also well adapted to bureacuractic coordination.

The chart of professional organization, as seen from Mintzberg theory of organizational bureaucracy (may or may not place it here).

2.3 Conceptual Framework

I have used Henry Mintzberg`s theory of organizational bureaucracy, as the main basis of my research study. This theory gives the general overviews of intra-organization and inter-organizational problems of coordination, and I will in turn use this theory to map and address the coordination problems in Health and Social Care organizations in general, and in Norway in particular. With these views in mind, I turned to present the organization theory of bureaucracy as viewed by Henry Mintzberg, and take the coordination aspects that relate to health and social care organizations.

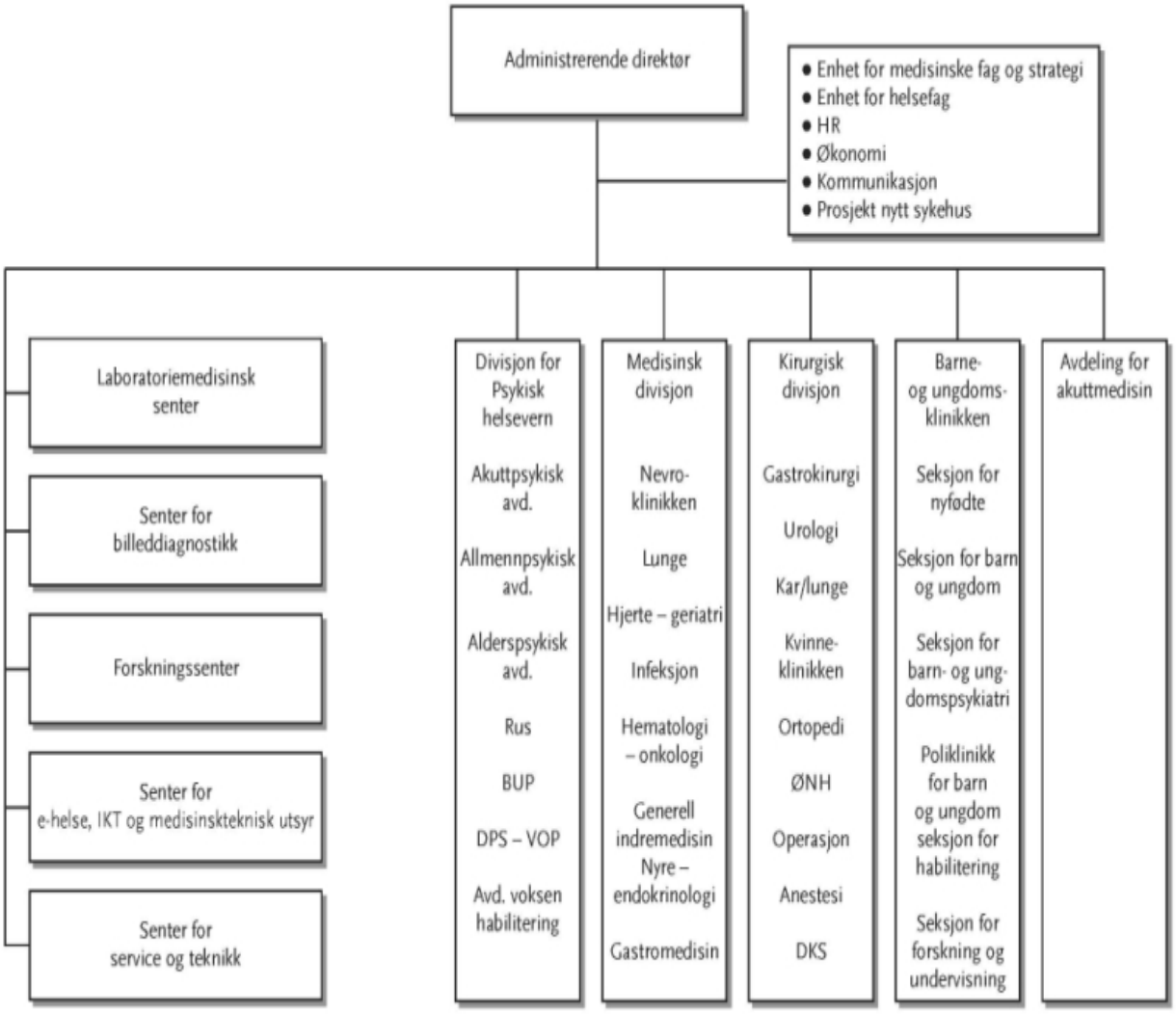
A bureaucratic mode of organization is one characterised by hierarchy (usually in top to down hierarchical order), sub-division of tasks, control and coordination through rules and managerial authority. Bureaucracies employ service providers to give service to people in need. The rules of bureaucracy that employs service providers govern their relationships to each other and to people in need (clients and carers). The typical examples of bureaucratic institutions are army, churches, public services like hospitals and universities and so on. The concept of bureaucracy originated from industrial organization and spread to other sectors of public services.

Application of bureaucracy, in bureaucracy the source of power to get people coordinate their actions is authority, authority is delegated from top to bottom by the employing body to managers, and is accepted as legitimate by employees who agree to be bound by rules and directions when they enter into an employment contract. Disputes and conflicts are resolved by reference to rules, or successively higher rulings within the bureaucracy, or by courts of law. Relations between managers and practitioners are also characterised by accountability, that is the right of managers to call practitioners to answer for their actions and inactions.

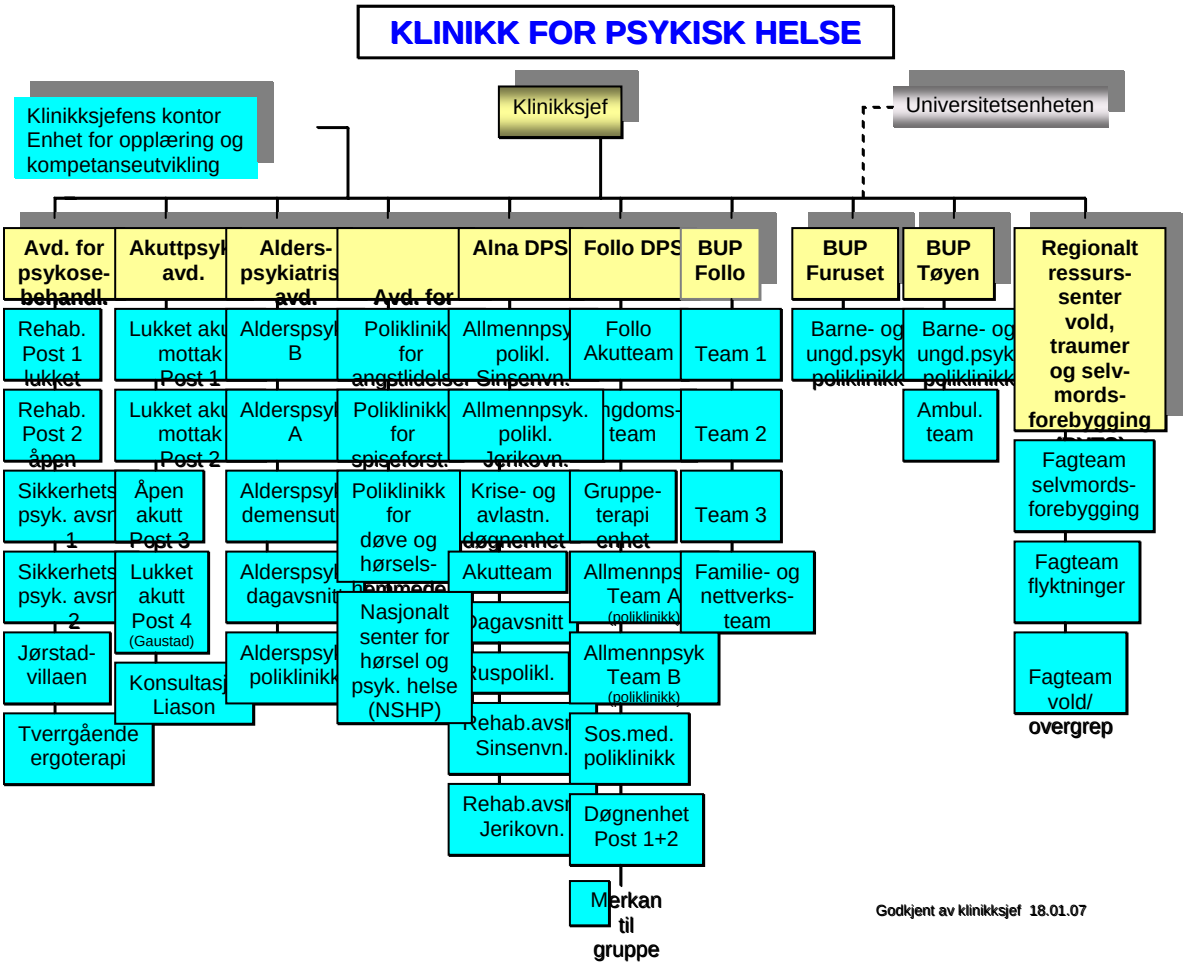
Relations between practitioners are governed by rules, backed up by the authority of the managers. Policies and employment contracts set sanctions for failures of coordination which can be applied by manager to whom practitioners are accountable. With this emphasis on authority and accountability, coordination between practitioners is best when they are under one manager, who makes the rules and give directions. When they are employed by the same bureaucracy, but under different managers, these managers need to agree rules and directions, or a cross-over manager higher up has to arbitrate. Coordination between practitoners employed by different agencies according to a bureaucratic mode of organization requires that their managers enter into bureaucratic agreements, typically joint policies.

Bureaucracies have a clear boundary, if a person is not employed by a bureaucracy he or she is not part of the organization, apart from a few exceptions like honorary positions. Critics of the bureaucratic mode of organization argue that services based on these principles are inflexible, slow unresponsive to client need and not able to adapt to a fast-changing environment.

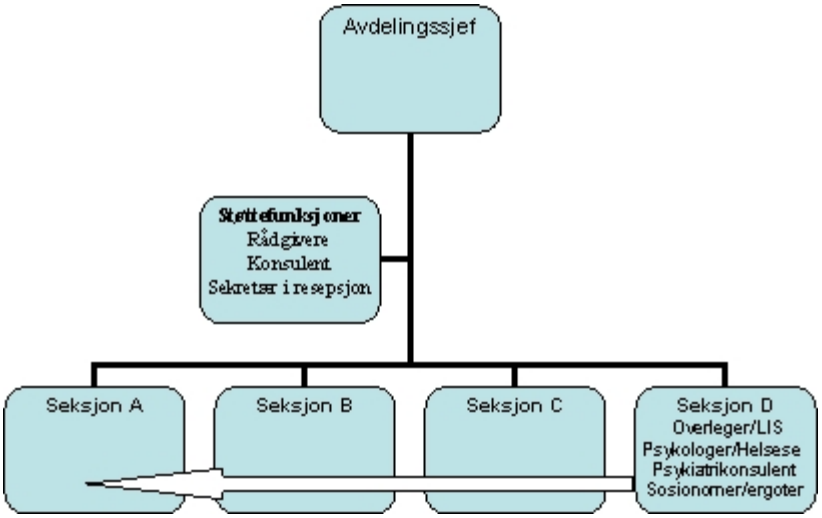
2.3.1 Chart of Professional Organization



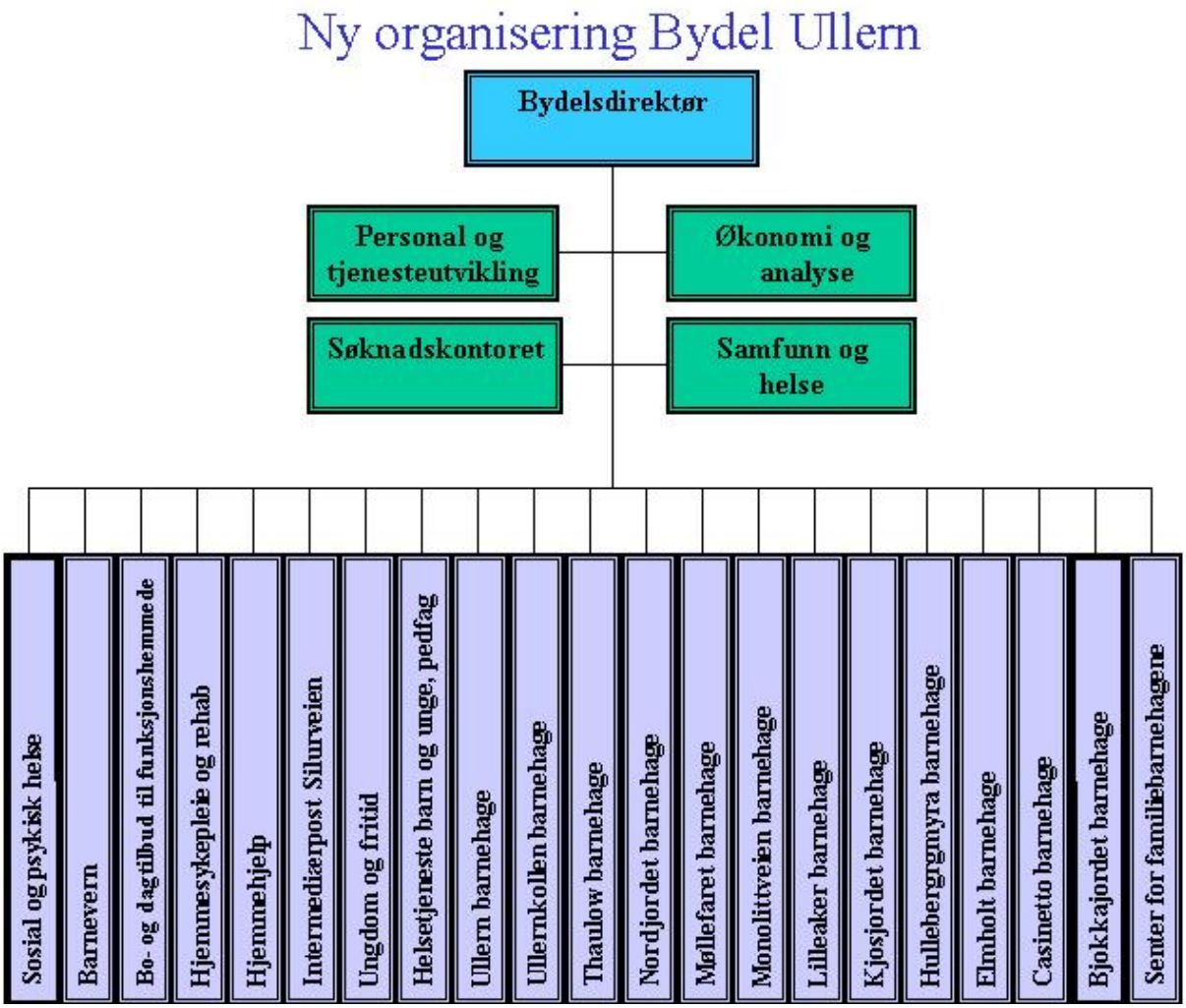
2.3.2 AUS Organization chart for department of mental health care



2.3.3 Organization Chart for DPC



2.3.4 Organization of Municipality for Delivery of Health Care and Social Services in Counties



2.4 The theoretical implication to population study

What are the implications of bureaucratic professional organization theory for psychiatric health care organizations?

The implication between the bureaucratic model of organization and the iatrocratic or professional organization in psychiatric health care organization is the resistance from the iatrocratic organization to be dominated or rule by the bureaucrats, this will affect the full interpretations and implementation of the rules and regulations which come from the above, and directed by the politicians, because the bureaucrats and the iatrocrats have different interests and gaols and the two apply policy in different time horizons. The physicians, roles, responsibilities and gaols for the patient is guided by medical

professional ethics which put patient first regardless of time and resource limitations, doing what ever it take to safe the patients from their suffering, and have short time goal and objective for the patients, that is healing the patient as soon as possible. While the politicians are occupied by sustainability of providing equal and economically effective provision of health care services to the population. They bureaucrats are occupied with cost containment and long term objective of health care services in economically sustainable manner. These differences affect the patient health care plans and will influence the quality of health care provision to them.

The differences between the professional organization and bureaucratic organization over goals, objectives and power to influence the decisions in the provision of health care services, more often result to premature discharges of patient from mental health care institutions to save cost and to leave vacancies for those in acute and on waiting lists, conflict of interest between the stakeholders in the health care organizations, for example economic interest between different health care providers can under mind the provision of health care services to the patients and can create inter-organizational conflicts between the various health and social care providers, this affect the mental health care patient the most because of the requirement of continuity, holistic and coordinated health care services between the various health care organizations which have different service goal and economic interests. Because they can not follow up and coordinate their health and social care needs, due to the nature of their mental sickness, they depend entirely on the good will of the health care providers to receive the needed health care services, that they are dependence upon and entitle to. Further the resistance to implement policy which come from above, by health care professionals will under mind policy coordination and the intentions of the policy and they effects on the patients, relative and hence the society.

2.5 Clinical Patient Pathways in the hospital

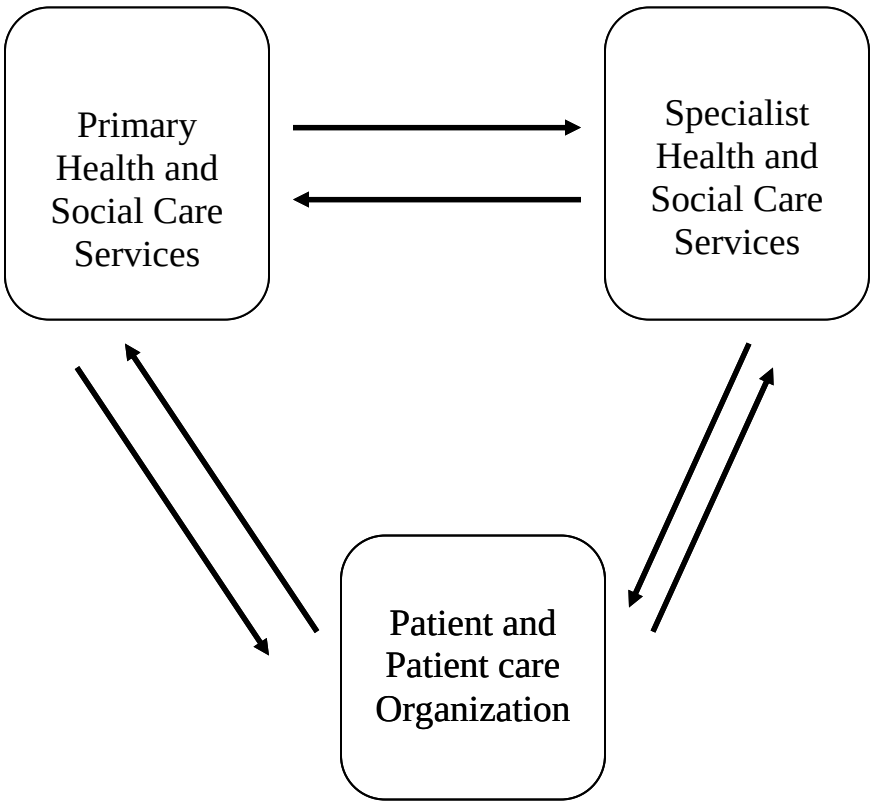
Patient pathways is the healing path patients follow through health care organizations, starting from primary health and social care organization by referral by GPs, health care worker and self-referral by individuals to the secondary health care organizations (hospitals, department of acute psychiatry and district psychiatric centres (DPCs)) and back to primary health and social care institutions or individual homes. It is worth mentioning here that some patient have long healing pathway from primary health care sector to secondary health care sector and back the same way to primary health care sector. While others have shorter patient pathways from primary to secondary care sector and discharge from the hospital alive and well, where as others discharge death that marked the end of their health routes. It is assumed here that each user has only one health pathway from the primary sector to secondary sector and back, this applies to my patient population with individual patient plan who receives continuous and coordinated health and social care services across the two levels of health and social care organizations (DHSA, 2006). And the binding pins between the two levels of health and social care organizations are the GPs, nurses, psychologists and sector coordinators from the side of primary health care sector, and from the side of secondary health care sector are the physician or psychologist in charge of patient, psychiatric nurses and sector coordinators in the hospitals.

Team members at the level of specialist or secondary health care services are the following: Physician or psychologist in charge of the patient, responsible nurse, GP, the individual plan coordinators from the two sectors, the patient and the relatives. While the team members from the primary health and social care sector may consist of the following: Patient`s GP, psychologist, sector coordinator, nurse, physiotherapist, occupational therapist, patient and the relatives or their representative. The membership in the teamwork for individual patient plan is dependent on the health and social needs of the concerned patient.

I have two models depicting patient supply logistics, the first model is a general patient flow or supply logistics which is a triangular model representing the coordination of health and social care services between the three stakeholders in the health and social care services, The coordination of health and social care services start from family institutions represented by patients and patient interest organization, primary and secondary health care organizations. The second model is presenting clinical patient pathways between primary and secondary health and social care organizations.

2.6.1 Coordination model

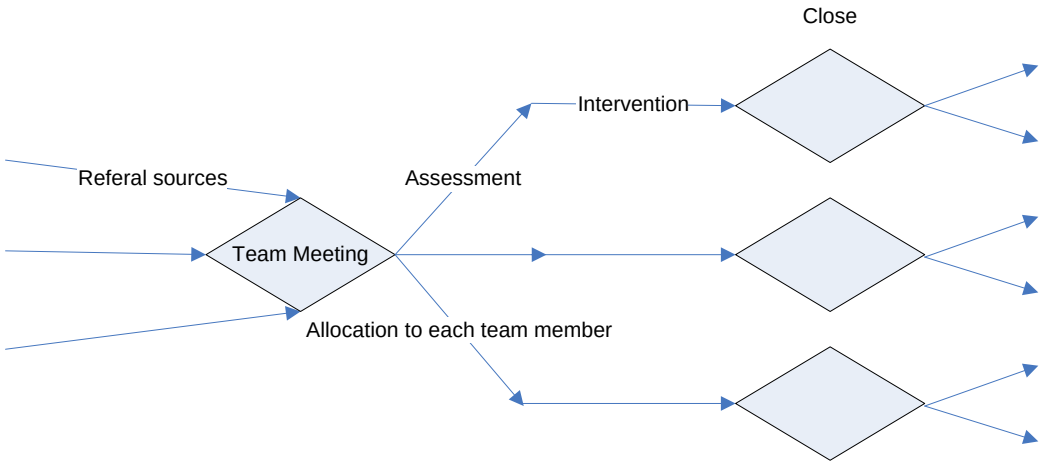
The Model for the Coordination of Health and Social care Services between Primary and Secondary Health and Social care organizations



2.6.2 Clinical patient pathways mapping frame work for individual plan

Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Referral by GPs and self-referral or relatives	Reception by Acute hospital Dept.	Admission	Treatment and Coordination	Referral to DPC or Discharge to Primary care

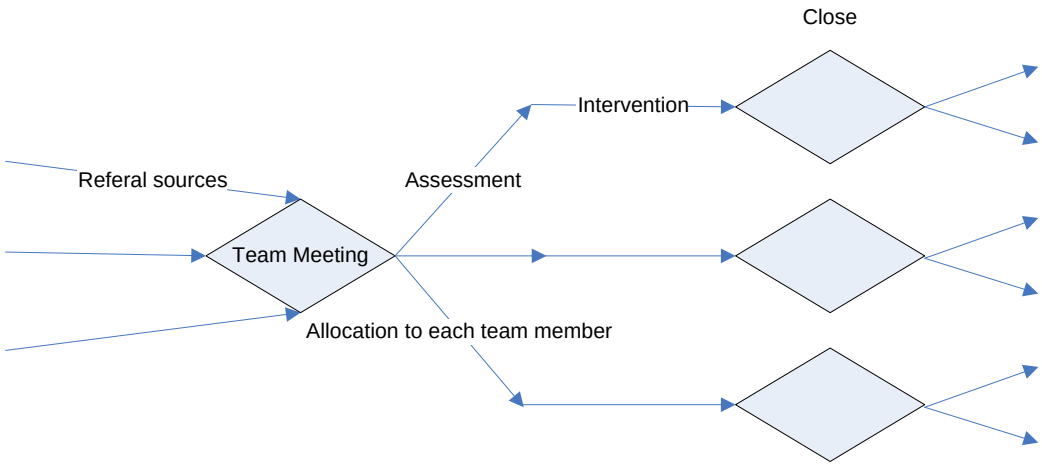
2.6.2.1 Chart of Clinical Patient Pathways



2.6.3 Clinical patient pathways mapping framework for individual plan

Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Referral Sources from:	Reception by Primary care Authority	Acceptance and Assessment by Teamwork	Allocation for Long term Care by Teamwork	Intervention and Monitoring by Patient Coordinator
Acute Psychiatric Dept. DPCs and Long term care				

2.6.3.1 Chart of Clinical Patient Pathways



Chapter 3: Research Methodology

3.0 Qualitative Research Method

My research study is conducted using qualitative research method to find answers to the research questions. The word research compose of two syllables, where re-meaning again and search which is a verb meaning to examine closely and carefully, to test and try or to probe. Together they form a noun "Research" describing a careful, systematic, patient study and investigation in some field of knowledge, undertaken to establish facts or principles (Grinnel, 1993). Where as, Dwyer and Limb (2001), refers to qualitative research as method that allows the acquisition of inside knowledge through interaction, observation and informal in-depth interview. Kumar argued from this definition that research is a process of collecting, analysing and interpreting information to answer questions. But to qualify this as research, the process must have certain characteristics: it must as far as possible, rigorous, systematic, valid and verifiable, empirical and critical.

To understand these characteristics better we must briefly examine what these words mean:

- Rigorous – you must be scrupulous in ensuring that the procedures followed to find answers to questions are relevant, appropriate and justified.
- Systematic – this implies that the procedures adopted to undertake an investigation follow a certain logical sequence.
- Valid and verifiable – this concept implies that whatever you conclude on the basis of your findings is correct and can be verified by you and others.
- Empirical – this means that any conclusions drawn are based upon hard evidence gathered from information collected from real-life experiences or observations.
- Critical – critical scrutiny of the procedures used and the method employed is crucial to a research inquiry. This means the process adopted and the procedures used must be able to withstand critical scrutiny.

In searching for the answers of my research questions, I have used qualitative research method. I have employed in-depth interview using both structured and unstructured interview guides in collecting primary data, analysing, interpreting and verifying the collected data to draw my conclusions, and then used the drawn conclusions to document my empirical evidences. In my research inquiry, I had used both primary and secondary data to find answers to my research questions, and start the research process by making contacts and later interviews with the following officials at the below institutions and asked for formal interviews with them one by one.

3. 1 Primary Data

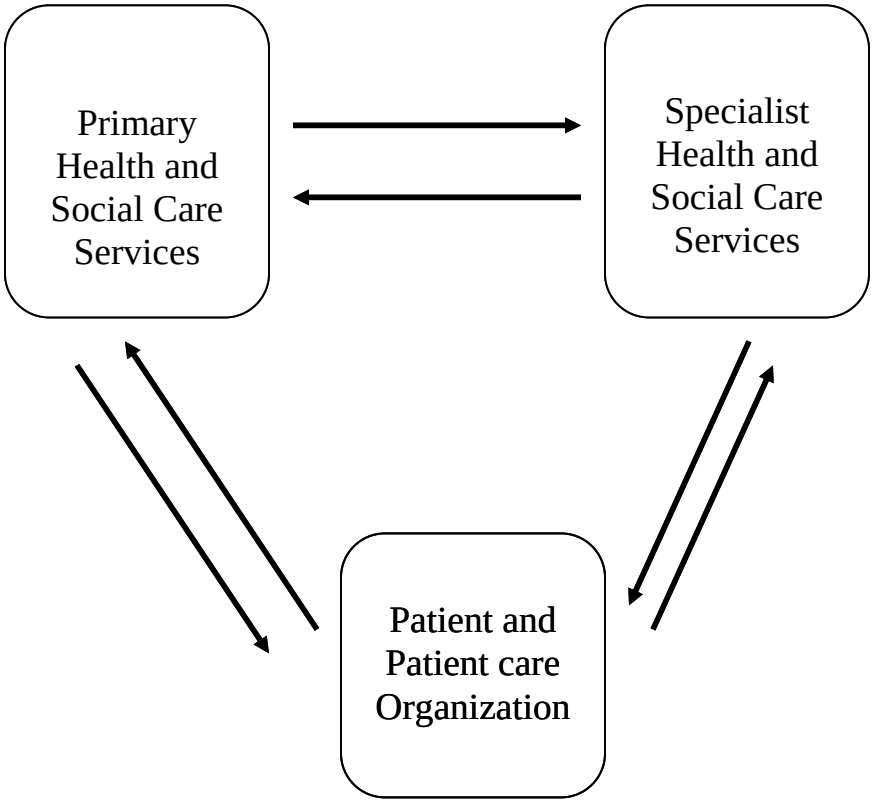
The method I used to collect my primary data is In-depth Interview model with unstructured and open-ended questions. Interview is face to face interaction between two or more individuals with specific purpose in mind that is the purpose of collecting data that can answer the research questions or problems. The theoretical root of in-depth interviewing is in interpretive tradition and according to Taylor and Bogdan, in-depth interview is repeated face-to-face encounters between the researcher and informants directed in understanding the informant`s perspectives on their lives, experiences, or situation as expressed in their own words (Taylor and Bogdan 1984:77). This definition

underlines two important characteristics of indepth interviewing, it involves face to face, repeated interaction between the researcher and the informant, and it seeks to understand the informant`s perspectives. Because of the repeated contacts and hence extended length of time spent with the informants, it is assumed that the report between the researcher and the informant will be enhanced, and that the corresponding understanding and confidence between the two will lead to in-depth and accurate information. This is the motivation and reasons for choosing this method for my research study. While the reason for choosing unstructured and open-ended questions is the flexibility it can give me in deciding the content and structure of interview questions, and it enables me to probe deeper in the problem areas and uncovered what lies behind the surface of the problems by using follow up question techniques.

In collecting primary data, I conducted in-depth interviews with the informants. The first step in my interviews process was to identify the informants, the criteria for electing an informant is based on the status of the institutions in national health and social care service. The roles and functions of the institutions in the provision of health and social care services, and in coordinating national health and social policy for the mental health care. The position of the informants in their organization, and their roles and responsibilities in coordinating health and social care services to mental health patients. My research study identified three main categories of informants, as mentioned above in criteria for selecting an informant, from the top is the Directorate of health and social affairs, which is responsible for health and social care plan, professional management and policy coordination, follow by Regional Health Enterprises, which are responsible for specialised health and social care services and primary health and social care institution, which are responsible for primary health and social care services in municipalities.

After having identified the informants, I have prepared three sets of interview guides, structured and unstructured open-ended questions, based on the roles and responsibilities of the informants in their various organizations. The content of the three sets of interviews guides are related, and all of the address the central theme of coordination of health and social care services, Mental health care programme, Coordination of national health policy including mental health policy, Management, organization and structure of health and social care institutions. The coordination of health and social care services is a triangular relationships between the stakeholders in the provision of health and social care services, and the stakeholders are The Primary and Secondary health and social Care Sectors and the Patients. The coordination of care services for chronically sick mental patients receive health care services across the two levels of the health care organization. Ole Berg illustrated these triangular relationships by a triangular coordination model below, and you can also find the full reviews of the informants list below:

The Model for the Coordination of Health and Social care Services between Primary and Secondary Health and Social care organizations



The Interviews Review Lists

3. 2.1 Directorate of Health and Social Affairs

Institution	Position of interviewee	
Directorate of health	Senior policy adviser	

3. 2.2 Regional Health Enterprises:

3. 2.3 Aker University Hospital

Institution	Interviewees positions	Names	Contact Information
Aker University Hospital	GPs representive/Patient Coordinator		
Follo DPC	Division chief		
Follo DPC	Sector Coordinator		

Akerhus University Hospital

Akerhus University Hospital	Position of interviewees		
Department of Mental Health	Director of the mental Department		
Psychiatric Department	Clinical Chief		

Ulevaal University Hospital

Institution	Position of interviewee		
Ulevaal University Hospital	Patient Coordinator		

The list of the informants from the primary health and social care institutions

Institutions	Position of interviewees		
Bydel Søndre Nordstrand	Psychiatric Sector Coordinator		
Langerud Nursing Home and Rehabilitation	Chief Nurse		
Bydel Alna	Psychiatric Sector Coordinator		

3. 3 Secondary data

During the interviews process, I went on along collecting secondary data from all the informants I conducted interviews with them. I collected document like National health care plan, secondary and primary health care plans, process documents, policy document, cooperation/contract agreements clinical guideline and other services protocol and etc. I analysed and evaluated these documents to validate and verify the information gathered from the primary sources.

3. 4 Reliability and validity

During data collection, I have encountered a number of problems due to having limited time for data collection. I had only two months period allocated for data collection, a study of this scale would have benefited from more time for data collection in the field. Due to limited time a number of organizations and personnel have not been interviewed. For examples clinical chief in the department of psychiatric at Ulevaal University hospital, the director of medical audit in the Norwegian board of health, the representative of mental health care organization in the Eastern health region. Clinical chief and patient coordinator at Asker and Bærum hospital and many other contacted organizations who have shown interest in being interviewed on my research subject. But they were constrained by time factors.

However not withstanding these setbacks, I was able to obtain valid and reliable data. My data are valid in all respects, because the information collected can be verified independently from the informants and other public documents that were used as secondary source of information during the data collection process. And to ensure validity in my data collection, I have used the interview guides taken from my from the research objective and the framework for analysis, provide me focus and guidance for

collecting valid and reliable data during the actual interviews. The concept reliability in research refers to the quality of measurement procedure that provides repeatability and accuracy of data that is unbiased and objective, meaning that you have taken each step in an unbiased manner and drawn conclusions to the best of your ability and without introducing your own vested interest (Kumar, 2005). Whereas validity refers to the extent to which and empirical measure adequately reflects the real meaning of the concept under consideration (Babbie 1990: 133). During my data collection I have followed my data collection instrument step by step with the aim of enhancing the reliability and the validity of the collected data.

To ensure consistency in the data collected from the primary sources are cross checked by rerunning the audio recorded interviews, notes and other public documents provided by the informants on the subject matter of the interviews and hence the research study. All these measures enable me to cross check the consistency of the data provided by the informants. As such the reliability and validity of my data is not in doubt, because of the confidence and experiences of my informant, backed by notes and documents they provided in connection with my interviews. Besides the informants answered my questions directly with absolute confidence in our face to face interaction, while our conversations are being recorded by Dictaphone.

Chapter 4: study population

4.0 Organization of national health and social care services

The national health and social care services are organized into two sectors, Primary Health and Social Care Services (PHSCS) and Secondary Health and Social Care Services (SHSCS), which is referred to as the first and the second lines of health and social care services. The two sectors formed the national health and social care systems, constituting both somatic and psychiatric health care services and the two sectors operate as two levels of health and social care organizations. The two organizations operate as independent and separate legal entity. However the two organizations are connected by National health policy, Health and social care policy of continuity, holistic and coordinated health and social care services for chronically sick or long term care patients, who receive health care services across the two levels of health and social care organizations. In the mental health care sectors, this national health policy is called Individual Patient Plan (IPP). The two health and social care organizations is further connected by shaving common patients population, and by mutually dependence on each other for sharing goal for patient and common information on patients when crossing from one level of the organization to another, which is necessary for the coordination and continuity of health care services without a gap in between the two sectors. The state is responsible for financing the secondary health care whereas, primary health care is financed by the municipal authorities and supplemented by earmarked state support. PHSCS operates as ordinary health and social care institutions, while the hospitals shall operate and manage as business like enterprises.

4.1 National Health Plan for Norway

The goal and objective of the government is to have the health and social care services to be of a high quality, to be available within acceptable waiting times and distances, and the provision to reach out to everyone regardless of their social status, financial situation, age, gender and ethnic background. The goals of national health policy is to ensure continuity, holistic and coordinated health and social care services through cohesion and interaction among the health care organizations, democracy and legitimacy through the hospital reform and the escalation plan for mental health care services. The government wishes to build health and social care services on the concept that the health care services should be politically guided and professionally managed, and the health and social care service be characterised by openness and participation between the physicians and patients or user of health and social care services. The patients have rights for information from the GPs and the physicians, and they have a say in medical decisions that affect their lives, and a good health and social care services must have legitimacy amongst and the trust of the general public.

The government pursue the proximity and security of health care services through the decentralization policy, where treatment and follow up shall continue to be organized according to the lowest, effective level of health care organization or LEON principle in Norwegian. This means proximity and local knowledge provide the best opportunity to individually adapted service provision with genuine users influence. Within the politically set limits, the management and staff of the health care service shall administer

the allocated resources in a socially beneficial manner. In the mental health care sectors, the mental care patients are given stronger users role in the provision of health and social care services through individual patient plan act. Professional managers in the two sectors have special responsibility to organize and implement the coordination where this is necessary. To ensure continuity and coordination of health and social services, cooperation or contract agreement will be signed between the primary and secondary health care sectors at the national level, and between the enterprise and municipal authority at the local level.

4.2 History of mental health care in Norway

The importance of the past for understanding the modern development in mental health care institutions in Norway, The problems of coordination in mental health care organizations is the main theme of my research study. To understand the modern problems in the health care organizations, one needs to go to the past to find the roots of the problems and for understanding the present day problems. According to Alex Thomson, the world does not radically reinvent itself on a continuous basis. It evolves. There are no total revolutions where all that has gone before is laid to rest, and a new polity is born enjoying a completely clean slate. Institutions, traditions, customs and social relationships will survive and adapt from one era to another. A researcher who wishes to understand the present must know something of the past. There are lines of continuity that run from the past period, through the present era right into the future (Alex Thomson, 2003). The same goes for the development of mental care institutions in Norway. As it will be seen, in the historical development of mental health and care institutions from 1748 to the present mental health care organizations, and the institutional reforms that had taken place and the reasons for the reforms. The historical development helped me to explain the changes in the organization of mental health care institutions. This justified my reason for searching history to shade light on my study population.

The history of mental health care institutions is the same with the history of hospital development which started from the seventh century in Byzantine, Greek and Arab theories of disease. Where from the tenth to the seventeenth century, it was referred to as a shelter for the poor attached to the monasteries, or as a feared last resort for the dying in the eighteenth century or asylum for the insane or isolation for incurable infectious diseases (Martin McKee & Judith Healy, 2002). It was financed by religious institutions and rich individual in the act of charity, for by favours in heaven, or showing solidarity with poor or to display individual power of wealth.

The history of psychiatric institutions started in Norway in the middle of seventeenth century, as a nursing shelter for the insane, poor and the disable who were depersonalized and isolated from the society for life time. The formal psychiatric institutions building started in 1848 with the codification of the law of insane, and which was later abolished and replaced by the law of psychiatry in 1961. Gaustad asylum was the first state authorised psychiatric institution in Norway and it was established in 1855. And additional three state authorised psychiatric institutions were established in Trondheim in 1872, in Kristiansand in 1881 and at Rønvik in Bødo in 1902. At the turned of the

century 11 state authorised psychiatric institutions were established in Norway with a total capacity of 1615 vacancies for mental care patients or insane people as it was called during that time. This number correspond to 7,2 vacancies per 10000 Norwegian population. Besides state asylums, there were also both municipal and private asylums, these private asylums were established also in 1848 which later got authorization from the state.

As the number of insane people grew resulting to over capacity problems in the state asylums which forced the state to build more insane institutions which reached it peak in the period between 1900 to 1920 with a total of 972 vacancies, then gradually started to decline in line with the concept of modernization, industrialization and the development of medical technology that gave some insane to get cure and discharge form long term psychiatric institutions. In the period between 1750 to 1900 the primary purpose for operating both private and state asylum were for socially isolating the insane and the incurable, the asylums were not meant for curative treatment. From 1900 to 1960, there were changes in asylum politic, where some of the new established state and municipal asylums were assigned responsibility to start curative treatment for those with good disease prognoses. People`s attitudes started changing about mental insanity as a disease and from being incurable to curable disease. From this period there emerged two types of insane asylums, the state asylums became curative insane institutions, while municipal authorised asylums were given sole responsibility for nursing and taking care of the incurable, which operate in the so called the colony system model of organization, where there is one central building for difficult people with high patient threshold which was surrounded by small buildings at periphery for easy patients with low threshold.

However, with the inhumane condition in the asylums, over capacity and escape of dangerous inmate and criminal insane from these institutions, coupled with the modernization and industrialization, and development in medical technology, the old style asylum institutions drew a lot of criticism from the society and became also unsuitable for curative medical treatment, which result into a new reform in the asylum politics. The new reform brought the division of asylum institutions into two sectors, the nursing homes for the insane in the counties became long term institutions for keeping the senile and dement people, and the state asylums became long term psychiatric institutions for keeping chronically sick mental care patients, where they received active medical treatment from 1961 and on ward. By the end of 1960s, there were 7235 vacancies in psychiatric institutions and 3055 in long term psychiatric care institutions, and 1026 vacancies in psychiatric polyclinics, and altogether there are11316 vacancies in psychiatric care institutions. By the end of 1997 this number was reduced to only 6368 vacancies. What is the relevance of these developments for my research study. It give me relevant information about my study population, the past problems in the psychiatric institutions, the reasons for the past reform policies, the connection between the past policy with the current policy. The reasons for the past reforms: critic from the population, inhumane condition in the psychiatric institutions, capacity problem, the rising cost of maintaining the insane, and early discharge of patient and escape of dangerous patient from long term psychiatric institutions, organization into sectors state and municipality, private and publicly. The present problems in psychiatric institutions,

critic from the population, over capacity, early patient discharge, poor coordination, rising cost, two sectors division state and municipality, private and public. Some of the psychiatric institutions we are seeing today adapted and remain as the testimony of the past historical development of psychiatric institutions in Norway.

The relevance of this short historical development in mental health and social care institutions for my research study is that it gave me a broader over view in the development of mental health care institutional development in Norway, from the conception in 1750s up to the present time. Historical development set trends, for one to understand the present, as my research findings uncovered some of the past problems in psychiatry are still giving problems in psychiatric institutions today like capacity problems, the rising health care cost, dangerous inmates escape from long term psychiatric institution, management and organization problems and so which will be found in the presentation chapter of research findings and the discussion chapter. For one to understand present one must start from the past development to be able to say something about the future. There are lines of continuity from the past, through the present and into the future, and history gives the best judgement (Borgny, Vold. 1999).

4.3 The characteristics of psychiatric institutions from the past to the present

Role of psychiatry	Time	Characteristics	Problems
Social isolation for insanes and infectious patients	1750 to 1900	Attached to religious institutions	No curative treatment and inhumane condition
Active medical care and social isolation	1900 to 1960s	Medical care and surgery with high fatality	Depersonalization, over capacity, rising cost and inmate escape from institutions
Sinnssykeloven	1848 to 1960	Colony system model of organization	Inhumane condition, high cost, over capacity and criticism of the system from the public
Psychiatric health care law	1961 to 1997	Two sectors institutions: State and Counties	Improved condition, over capacity, early discharges
Mental health care act	1999 to 2008	Individual Patient Plan (IPP), Personalized and patient and patient empowerment, Two sectors division Primary and Secondary health care, Application of integrated organization model in mental health care sectors, Acute Department and DPCs in the municipalities.	Problem of coordination, capacity, rising cost, premature discharges from the hospitals, public criticism of the system, inter-organizational conflict and disagreement, organization and management problems and etc.

Chapter 5: Presentation of my research findings

5.0 Introduction

The information contained in this part is a result of my indept interviews with the following Directorate of Health and Social affairs, Primary and Secondary or Specialised Health and Social Care Services (specialised hospitals, and they are Aker University Hospital, Akershus University hospital, Ullevaal University Hospital and their respective District Psychiatric Centres). This report is based on analysis and interpretation of information collected during the interviews and secondary information provided by the informants.

The information contained in this part is a result of my in-dept interviews with the Directorate of Health and Social Affairs (DHSA), secondary and primary health and social care services. This report is based on analysis and interpretation of information collected during the interviews and secondary information provided by the representatives of Department of Mental Health Care at the DHSA, secondary and primary health and social care organizations. The aim of the interview with the informants is to get more information concerning the challenges in implementing and coordinating Health and Social Care Policy from the part of DHSA. Especially the policy for coordinating mental health care programme, its role and responsibility as a central authority for delegating and implementing National Health and Social Care policy, and the problems in coordinating health and social care services from the sides of primary and secondary health care organizations. This interview is in lined with my research objective which was to identify the challenges in coordinating Health and Social Care Services (HSCS) to chronically ill mental health care patients. The research challenge was to identify the problems, the cause of the problems, is the central authority aware of the challenges, what are the efforts being made by the central authority to alleviate the problems, and how do the authority feels concerned about doing something about the problems.

Since I have conducted in-depth interviews with only one or two informants from the institutions mentioned above therefore, I will present the coordination problems and challenges in general and in a qualitative research method. The problems that my research study uncovered are the Problems in implementing National Health and Social Policy, individual patient plan, patient follow up and rehabilitation, economy, capacity and competency, communication and information, Earmarked budget or State support grant, Cooperation or Contract Agreement, Individual patient plan, Quality control mechanisms like internal control, guidelines and routines. After having identified the problems, I will also try to point out their causes. I will try to relate the research finding to the problems of Coordination as discussed in the chapter of research methodology and conceptual perspectives according to Henry Mintzberg`s theory of organizational bureaucracy, that I had used to map up the coordination problems in the Norwegian Health and Social Care services.

The objective of my research study was to identify the challenges and problems of coordination of health and social care services to chronically ill mental health care patients. These patients have needs for comprehensive health and social care services

from both the primary and the secondary sectors. This is because of the nature of their mental illnesses, and the complexity of health and social care organizations involved in the provision of health care services. The delivery of comprehensive HSCS is necessary for the patients in order to manage their live and daily activities like any other members of a society as provided by Mental Health Care Act or Individual Patient Plan Act. Since the mental care patients can not coordinate their needs for HSCS, they need some one to coordinate these services for them. It is here that organization and coordination of HSCS is very important for ensuring the continuity in the delivery of care services to the individual patients without interruptions from one level of HSCS organization to another, and from one service delivery agency to another in a coordinated ways. It is worth mentioning here that, this is a complex provision of health and social care services, involving multidisciplinary health and social care professionals, working in teams to meet the health and social needs of individual patients. The complete provision of health and social care to individual patients by different providers and agents, present considerable coordination challenges to health and social care organizations.

It is this complexity and challenges of health and social care coordination to mental care patients and the consequences of failed coordination of comprehensive health care services to them, their relatives and the society that motivated me to find out the challenges and problems in health care coordination between primary and secondary health care sectors. Since I have conducted in-depth interviews with a limited number of informants from the above mentioned institutions, therefore I will present the coordination problems in general and in a qualitative research method. After having identified the problems, I will also try to point out their causes. I want also to find out what the professional managers are doing at the clinical level to alleviate the problems. Further, I will try to find out to which extent the problems identified, are recognized by the central authorities, and to which extent these authorities like the Directorate of Health and Social Affairs, Regional Health Enterprises (RHE) and Primary Health and Social Care institution feels that it is their duty to do something with the problems, and what plans do they have to solve the problems. These problems were refers to as Intra-Organizational and Inter-Organizational problems of Coordination according to Henry Mintzberg`s theory of Organization Bureaucracy. That I used to map up the coordination problems in this research study. Accordingly, the following are coordinating challenges as they were uncovered by my research study, and these challenges included the application of National health policy, organization and structure of health and social care institutions, individual patient plan, Patient discharge routine, patient follow up and rehabilitation, communication and information problem, capacity and competency problems, economic problem and the contract or cooperation agreement between primary and secondary health and social care organizations. The sequences of this presentation start from the Secondary and Primary health and social care sector and followed by the Directorate of Health and Social Affairs, and the summary of the presentation at the last part of the chapter.

5.1 Secondary Health and Social Care Services (SHSCS)

The information contained in this part is a result of my indept interviews with the following specialised hospitals, and they are Aker University Hospital, Akerhus University hospital, Ullevaal University Hospital and their respective District Psychiatric Centres. This report is based on analysis and interpretation of information collected during the interviews and secondary information collected from the informants. The report contained intra-organizational and inter-organizational challenges of coordination, as it is viewed by the informants. These challenges stem from the organization and structure of department of mental health care hospital, individual patient plan, Patient discharge routine, patient follow up and rehabilitation, communication problem, capacity and competency problems, economic problem and the contract or cooperation agreement between primary and secondary health and social care organizations.

The organization of hospital psychiatry department and District Psychiatric Centre (DPC) are situated in different geographical locations and far from each other, and this is the same with organization of the DPCs, they are located far from each other in different localities. This creates leadership and administrative problems of coordination, because of the lack of physical contact between top management team and the employees of the organization located in different districts far away from the main hospital, where main head office is located. The barriers to communication develop between the top managers and the divisional leaders in their various locations, because of lack of physical contacts. Although there exist continue communication between the DPCs and the department leadership, through telephone and internet, but face to face interactions between them is lacking, which is necessary for a common understanding of job challenges face by staffs from first hand information, and to be able control the situation from the site, rather than learning from a distance place through telephone or internet.

The physical contact among top management team is not frequent, due to long distance between the mental departments at the hospitals and the divisional leaders in the districts. As a result meetings have to be planned in good time in order to avoid interrupting the usual working routine of the employees, and have to be planned in advance with a few selected staffs who will attend such a meetings, the long distance between the various DPCs and the administration, and between the DPCs with each other and the administration offer coordination challenges, the feeling of independence and the growth of cultural differences between the various units of the department, because of less contacts between the rank and file of the organization in different locations, besides the other barriers to communication. The informants have reported the existence of cultural differences between the different divisions and units of the organization. My informants reported also of the existence of competition between the units, the DPCs and there is also inter-professional rivalry among the units. Organizational staff meetings at lower levels are rare. Emergency and crisis meeting take time for coordination, and the use of economic incentives from the side of top management team to attract employees in some DPCs location creates conflict between the DPCs or between the various units.

The challenges seen here from the theoretical perspective is a bureaucratic problem of leadership, intra-organization problem of coordination and communication (H.Mintzberg). The department management are ware of the problem, as a practical step to alleviate the mentioned problems, they are restructuring the mental health care department, to make the organization even flater by having only one department director, who is also the director of various DPCs divisions, and in turn the DPCs is headed by clinical chief who is directly under the department director. The aim of this organization restructuring is to have management control, shorten bureaucratic chain of hierarch in mental health care organization, and further this restructuring will facilitates coordination and communication between the department and DPCs divisions. In order to prevent cultural differences within the various divisions and units, there are regular personnel exchanged between the department and the DPCs, holding regular leadership meetings, staff meeting, common seminar, consultations, intranet and joint social activities. The challenges to these restructuring is lack of experience in the effectiveness of the reform to achieve its objective and in finding the right balance between routine work at individual posts and the necessity of frequent informal meeting to enhance cooperation and common identity among the staff at different divisions and units of the department.

Medical report, Patient coordinator or responsible doctor for individual patient changes as soon as patient is transferred from one department to another, for example from department of acute psychiatry to DPCs, this continuous changes create coordination and logistical challenges, and problem of having overview of patient clinical process and pathways at any given moment, because the system is dynamic, and things happen and move very fast in medical process. The system need to be updated from time to time to take account of this fast changes in the patient logistics. These changes create a lot of work loads of follow up and record updating, including patient clinical process records and so on. This rapid changes couple with emergent cases of admitting and processing new comers at the acute department, give little time to physicians and nurses to update, follow up and coordinate, and at the same time writing medical journal and report of discharged patient waiting to leave the hospital. In addition to the mentioned challenges, the law of confidentiality on patient information, restrict free exchange of patient information from one department to another and from one unit to another “It is a difficult and complex business and it takes time to write one report” is the quotation of one of my informants about the coordinating challenges in patient logistics, it is a time consuming task for physicians in the hospitals, concluded this informant. The problems above are connected with capacity and resource problem, interruption in programmed work, intra-organization problem of coordination and communication from the theoretical standpoint. The earmarked state fund was designed to alleviate the capacity and resource problems in mental health sectors, but it is not sufficient to solve the capacity and economic problems concluded the informants (John Øvrevelt)

The increasing number of acute patient and emergency cases, lack of a few competent personnel overstretch the capacity of a few staffs on duty, and the hectic nature of hospital working processes, were reported by my informants to be the main reasons for the delay in processing medical journals and reports, besides incompleteness or unclear content of patient journals or reports, that results in coordination and communication

challenges between primary health and social care institutions and the hospitals. The information gap caused by incompleteness or unclear medical records, make it difficult for medical professional at primary care level to interpret and make use of the information on medical report for the continuation of services for the discharged patient from the hospital, the unclear or incomplete information on patient report, affect patient recovery and the continuity of health and social care services for the after discharged from the hospitals, it creates also service and follow up difficulties for health and social care personnel at the primary health and social care level. The research theory refers to as policy implementation problem that is failure in following clinical guideline, and problem of skill personnel and lack of time to perform assigned task. All the informants complained of having acute demand for skill personnel in the hospitals and the annual increase in their budget can not meet the demand for personnel. My research study identified this problem as the problem of implementing clinical guideline or internal control at system level of the hospitals (H.Mintzberg).

Where as, the coordination challenges and problems between the specialized and primary health and social care organizations is caused by lack of sufficient information between the two levels of health care organization. Without sufficient information on the patient, it is difficult for health personnel in the primary care sector to continue with patient health and social care plan. The two levels of health and social sector are mutually dependent on the comprehensiveness of information provided by the counter part of providing services to the patient. The other challenges of coordination between the two sectors of health and social care organization is caused by individual patient plan, Patient discharge routine, patient follow up and rehabilitation, information and communication problem, capacity and competency problems, economic problem and the contract or cooperation agreement between primary and secondary health and social care organization. This problem occurs at the linking pins levels of the two organizations, it is iner-organizational problem of coordination occur between patient coordinators, GPs and other health care managers at the primary care institution). I will give detailed implications of these factors in the discussion part of the research findings.

On the organization and structure of mental health care plan, the informant share common views that internal process system is not working optimal, the organization structures created management problem for the health care manager like quality control, barriers to communication and coordination, because of the separation and distance between hospital department and divisions and units, that are placed in different location and far from each other. As a result of improving the delivery of health and social care services, the mental health care plan is adopting integrated model in mental health care organization in order to make the structure of the organization flatter to easy coordination and communication difficulties between the department, DPCs and mental hospitals. The management is encouraging the exchange of personnel like physicians, psychiatric doctors and psychologists between hospital and DPCs aimed at encouraging communication and cooperation, share common values or culture, talk to each other, interact with each other to strengthen ties and unity of the organization. Further they are organizing common seminars, meetings and other social gathering with all the employees

of the department including DPCs to promote share value and unity among the employees of the organization.

There are further problem of admission in the acute department because of high patient thresholds, capacity and accommodation shortages. The management is planning to work in closer cooperation with the primary care sector to solve Week-end problem in discharging mental patient from the hospital, increase number of acute outside psychiatric team and ambulance team to reduce capacity and waiting list problem who are working in the districts, established joint patient follow up projects together with primary health care sector, increase leadership meetings and seminars between the two sector to create mutual trust, understanding and cooperation among the two sectors. Efforts are being made to solve the problem of substitute, capacity, and personnel by lobbying for more fund for employing health care personnel. While for patient medical journal and report, the organization is working to simplified, clinical protocol, internal process system, the complex journal writing and reporting is being reform and are working on simplified versions. This problem is identified by my research study as leader ship responsibility in ensuring that delegated laws and clinical guidelines are fully implemented by the responsible personnel at every process stages in patient supply process logistics. I will come back with detailed implications of these factors in the discussion part of the research findings.

5.2 Primary Health and Social Care Services (PHSCS)

The coordination challenges in primary health and social care services, consist of both intra-organization and inter-organization challenges, this report is based on analysis and interpretation of information collected from the informants during the interview processes. The representative of health and social care managers that I had interviewed were the following, Representative of GPs, representative of District medical officer, District and sector psychiatric coordinators, Psychiatric nurses, Head nurses of home care services and nursing home and local authority. This finding is based on informants` views and experiences of coordination challenges facing them in the mental health care sector. The general information, I got from the informants was that the main challenges of coordination facing them in the primary care sector are the organization, management, economy, personnel, capacity, competence, structure and routine of coordinating HSCS to mental health care patients with individual plan. According to the informants, the informal structures of coordination in the municipality operate independently, resulting to fragmented or partial delivery health and social care services to the mental care patient. This disorganization is causing a lot of frustration among the employees providing health and social care services to mental health patient.

The fragmentation of primary care organization is making the coordination of services difficult for the manager of care services. They said that the structure of coordination is function well at the top leadership level, where there is structure and routine for coordination, but this has little effects at the lower levels or unit levels of the organization. The various units involves in the coordinating HSCS to individual patient is disorganized and fragmented, because various organizations, agencies and units providing HSCS operate independently of each other. There is little or limited structural

support to ensure complete, and coordinated health and social care services for individual patients, as this is causing frustrations among personnel that provide services to patients, because of lack of coordination, for example a patient with a service demand in another unit or section , can not get the service needed automatically, a patient coordinator has to make an appointment, take queue ticket and wait service for the patient like any other person queuing for the service. This takes unnecessary time and inefficient use of personnel resources. This uncoordinated delivery of services also causes frustration and uncertainty with the individual patients, said the informants. My research study identified the above problems as leadership responsibility for not creating a common forum for coordination or mechanism for managing intra-organization inter-connectedness and dependence to enhance cooperation and communication between the different organizational divisions and units (H.Mintzberg).

The informants reported also that coordinating multidisciplinary team for individual patient is not working according to plan, the reasons being among others, because of lack of attendance from the various team members or not keeping time schedule, and among these team members who rarely attend team meetings are the GPs who are also patient coordinator in most cases, I was told. While the GPs usually give various reasons for not attending team meetings, that they are not participating in team meeting regularly, because of attending to acute patient care or an emergency case with their patients and so on. However my research study uncovered the underlying reasons for not participating in various teamwork is the economic reasons and lack of binding contract or cooperation agreement between the GPs organization, primary and secondary health care organization. Economically GPs have little incentive for participating in multidisciplinary teamwork, they lost a lot by participating in such in teamwork than carrying out daily routine work. Further, “because GPs organization is not a party to the cooperation agreement between primary and secondary health and social care organization, therefore GPs do not feel obliged to attend multidisciplinary team meetings on regular basis like the other members, and are selective in attending such meetings.

The common view among the GPs is that if they are formally included in the cooperation agreement between the primary and secondary health care organizations, perhaps they can negotiate a better term for participating in teamwork as equal partner with the other parties to the cooperation agreement” concluded my informants.The consequence of lack of attendance or reporting late can postpone or delay an important team decision making processes on the individual patient, this cause uncertainty and frustration among the team members. The delay in making medical or social care decision also affects medical outcome of the concerned patient, and the function of multidisciplinary team, is to access and evaluate the health and social care needs of a patient. The lack of attendance from the members or delay in taking important decision on patient health and care, due to team member`s absence is what causes frustration in the teamwork. This problem is identified by my research study as the problem of inter-organizational problem of cooperation (H.Mintzberg). The underlying reasons for lack of cooperation among the different parties in the delivery of health and social care services to individual patients is that the parties have different service goals and economic interests.

The patients follow up and rehabilitations, is other coordinating challenges facing primary health care sector for patient on individual plan. These patients demand a lot of resources, like housing, personnel and economic assistance to meet their daily health and social care needs, some of these patients need monitoring and assistance on 24 hours basis. The municipal authority have limited earmarked budget for them, and a few competent personnel and capacity to take care of these patients in their resident or institutions. There is acute demand for housing for mental care patient in all the municipalities I visited, the housing problem is cause by increasing number of psychiatric patients being discharged from hospitals and other mental health care institutions to be rehabilitated in community, the hospital normally give two weeks notice for receiving and accommodating a mental care patient. This is a short period to prepare a suitable accommodation for a long term mental care patient, special housing facilities are difficult to get and are normally expensive for the local authority to afford, besides the houses require care personnel to work in these special house to give health and social care services to the patient, this overwhelm local authority and therefore create coordination and capacity problem for the primary care authority according to my informants. There is acute demand for psychiatric nurses, psychologists and social workers in the municipalities. Small funds are earmarked for employment housing and capacity building in the primary health care sector to meet these challenges. In addition to coordination problems within the primary care sector, there are also inter-organizational coordinating challenges between the PHSCO and SHSCO.

My research study identified this problem as the cooperation and capacity and resource problems between the two parties, patient discharge and follow up is not properly coordinated between primary and secondary health and social care authorities. The parties are fully aware of the problems and working to improve cooperation between them by involving all the parties in the early stage of individual plan processes, and by participating in a joint project of patient follow up and are making appeal for more fund to enhance capacity and competency in the two health care sectors, through annual state budget processes.

While inter-organizational coordination challenges between the primary and secondary health and social care services is the problem of implementing the patient individual plan and the follow up and rehabilitation of chronically sick mental patients, who needs health and social care services over a longer period of time. The main causes of the challenges of coordination is over disagreement between primary and secondary health and social care services, this disagreement is often over economic responsibility for the patient follow-up, who will be coordinator, follow by the role and responsibility of this coordinator. The mental patient group who fall under this category are patient admitted and discharge from the hospital for the first time, without prior individual plan, these patients have a lot of needs for health and social care services like special housing that suit their mental health and social conditions, varieties of other health and social care services, and are to be coordinated, both hospital and primary care have capacity problems, hospital need to discharge patient as soon as their services are no required, giving vacancies to new comers, while commune need also need to find suitable facility to rehabilitate the discharged patient from the hospitals, all these services required a lot of

resources and is the main causes of the disagreement between the primary and secondary health and social care organizations.

There is also coordination challenge between the two parties that cause by medical decision to discharge a treated patient from the hospital, the dispute is over whether a patient is ready for discharge and discharge routine, these uncertainties from the part of the hospital is that caused disagreement between the two parties. The dispute between the two parties is over economic responsibility over the patient, accommodation, the follow up and rehabilitation services required by the discharged patient. In many cases these disputes end in the of arbitration committee or in court in some cases. There are a number of examples of such cases, where one went in favour of primary of primary care, other in favour of specialist care and another the cost was equally divided between the two parties in the dispute. Besides dispute over economic responsibilities, there are disputes between the parties over accommodating discharged patients who can not leave the hospital because the have no where to go, for hospital need vacancies for admitting new acute patient, while for the commune they do not have a ready facility for accommodating the discharged patients. Acquiring a special house to meet the housing need of the sick, take a long time to get, alternative is to rent apartment from the neighbouring district or private sectors which are often expensive for the municipality to opt for. This is identified as lack of cooperation and taking common responsibility for the best of the discharged patients.

Other challenges are when a mental patient with individual plan under the responsibility of municipality denied to receive the need HSCS due to worsening mental condition, then a crises develop due to lack of cooperation between municipal authority and the hospital over who is responsible for such a patient, in most of such cases commune pushes the responsibility over to the hospital and the hospital will also denied responsibility for the patient, where the responsibility for the patient will hang in between the hospital and the commune, with a dire consequences for the patient and the relatives, this happens more often with schizophrenia patients. In such cases readmission is difficult in the acute department and the primary care authority lack competence and capacity to handle the patient, according to my informants.

The other coordination challenges reported by informants was that delay and information quality of the patient medical report and journal, when a patient is discharged from the hospital he or she is suppose to come along with this form, it was reported by the informants that on many occasion patient come without this medical report. The absent of medical report make it difficult for the concern authorities in the primary sector to continue with the medical and social plan for the patient, because of lacking basic medical information on the concerned patient. When the patient contact from primary health and social care sector, get contact with the doctor or nurse in charged of the patient, it is often difficult to establish contact with them, they may be off duty or were working as substitutes and their colleagues don not give information about their patients, because of information confidentiality on patients. Sometimes one patient may have two or more doctors in charge of their case and follow up, due to internal transfer from one department to another in the course of the treatment process, this happens more often

with mental care patient, are first admitted in acute psychiatric department, then transferred to DPC and discharged from there to go home of other primary care institutions to continue with further medical treatment or follow up.

In other cases, the medical report may lack basic information requires, additional clarification or information given is difficult to interpret for health and social care personal from primary care sector, my informants have reported meeting this kind of problem more often. These problems cause a lot of difficulties, uncertainties and frustrations to health and social care personnel in the primary care sector. There is uncertainty over the role and responsibility for the discharged patients in the absence of patient personal coordinator in the hospital. My research study identified this as the problem of implementing delegated law regarding individual plan from the central health and social care authority and implementing the clinical protocol which is the responsibility of the clinical managers in the hospitals and DPCs unts outside the hospitals.

5.3 Directorate of Health and Social Care Services

The Directorate is one of my main informants on the general coordination challenges in the organization, structure, plan and policy of the Norwegian Health and Social Care services (HSCS). The Directorate is a part of the central administration of health and social affairs in Norway. It provides advice and guidance on strategies and measures to the Central government, municipalities and health enterprises. The Directorate was established to ensure availability of health and social care professional capacity in the health and social sector, to administer health and social legislation concerning legal capacity and responsibility for implementing health and social policy, by delegating its authority to the regional health enterprises and to the municipal authorities. It is because of this central role and responsibility in health and social affairs, that the Directorate is directly or in directly implicated in the coordination challenges between the primary health and social care services (PHSCS) and the specialised health and social care services (SHSCS). It was also because of the central position of the Directorate in health and social affairs that I turned to it for information concerning coordination challenges in the health and social care organizations. And particularly, to give me important information about the challenges of coordination in mental health care sector which is the subject matter of my research study.

5.3.1The problem of implementing national health and social policy

The Directorate of Health and Social Affairs (DHSA) is responsible for the administration and the implementation of national health and social policies with the aim of achieving the national health and social care objectives. However in practice delegating policy from top to bottom is one thing and implementing the delegated policy from below is another thing. It is here that the problems of coordinating national policy arise, because the DHSA is in practice implementing the policy by delegating its authority to the Regional Health Enterprises (RHE) and to the Primary Health and Social care Institutions in the Counties and Municipalities. The DHSA is not directly in control of how the policies are being put in action at the lower levels of the health and social care organization. The problems is due to the fact that some of the health policies delegated to

the lower level are not fully implemented by the health and social care actors, the examples are the cooperation agreement between the hospital and local municipal authority is not sign and implement by all the local municipal authorities, there is also variation in the practices of clinical guidelines in the hospitals and the requirement of the law, the example of a sighted law is the Specialized health care law § 3.7 on patient coordinator or responsible physician in charge of a patient which is identified as problem of implementing clinical guidelines, besides other different interpretation of rules and regulations of health and social care policies. The cooperation agreement between RHE and the county, and between hospitals and the municipalities which is identified as the problem of inter-organizational problem of coordination. The Earmarked state grant for Mental health care that is also causing workloads and reporting problem in health and social care organization and this is identified as the problem of policy coordination in bureaucracy, and further Individual Patient Plan (IPP) which is a policy coordinating mechanism in the mental health care is also causing conflicts between the RHE and the primary health and social care authorities and this problem is identified as the problem of inter-organization problems of coordination and cooperation.

It is at the level of hospitals and primary health and social care institutions that the problems of policy implementation are found according to the research findings. The problems of implementing health and social policy is connected with the application and interpretation of rules and regulations like clinical guidelines or protocols in the hospitals and primary health and social care institutions by health and social care professionals in the coarse of exercising their professional duties and responsibilities (problems connected with patient journal and medical report in patient logistic and clinical process) which is Intra-organizational problems of coordination. This problem is identified by the research theory as the problems of delegating authorities from Top to Bottom in hierarchical order by a bureaucratic professional organization like the health and social care organization and other public service institutions.

The DHSA is trying to be précised and explicit about the contents of policy instrument delegated to the lower levels of health and social care organizations in order to avoid ambiguities in the application and interpretation of the policy that is translated into rules and regulation at the lower levels of health care organizations. The conflicts area between the RHE and the PHSC organizations is over role and responsibility of patient follow up after discharged from the hospital. The conflicts are more often in economic responsibility of provision of health and social care services to a discharged patient, the conflict arise as a result of ambiguity and interpretation of health and social care laws and in the cooperation agreement between the two parties. The conflict is identified, and recognized by the central authority, by forming arbitration commission, which is neutral and independent body formed with the aim of solving inter-organizational problem of coordination between the two sectors of health care organization. This is seen from the DHSA as taking responsibility for what happened in health and social care system and finding acceptable solution to a common conflict between the parties. The health authority further encourages the parties to form and work in joint projects with the aim of encouraging cooperation, understanding and respect of each other. This is what the research theory refers to as solving inter-organizational conflicts. The DHSA delegate the

controlling authority of implementing health and social policy to the county and municipal medical officers to help the health and social care professionals in the counties and municipalities with policy and legal issues. The Counties and Municipal medical officers act as medical advisors in the counties and municipalities. The DHSA organizes also a joint seminar for health and social care professionals from the two sectors to address and highlight outstanding policy problems in the provision of health and social care services to the affected patient population. In this regards, the DHSA gives health and social care guidelines, professional health reports, journals and magazines to communicate, coordinate and discuss common policy problems and challenges to national health authority. In acting these ways the DHSA is performing its national duties of policy delegation, coordination and implementation in health and social care organizations

5.3.2 Individual Patient Plant (IPP) is another factor creating disputes between the health and social care sectors. The dispute is cause by early discharges of mental health care patients from the hospitals, incomplete and unclear information in the patient journal and medical report, patient coming without or delay of the reports, contact difficulties, short notice for patient discharge, lack of patient follow up and admission problems in acute mental department and so on. The DHSA initiate the Earmarked State Grant specifically to address the economic but the earmarked grant created in directly the problem of implementing the IPP in the mental health care sector, by creating unnecessary accountability and workload for health and social care managers.

As a step to alleviate the problems, the central authority is holding joint meetings, seminars involving DHSA, Norwegian Board of Health, Public health institute, health and social care professional from both sectors to discuss issues connected with implementing IPP and other reported problems with health and social care professional at all levels, aim at sharing information, experience and common understanding of the problems in implementing IPP. Other measures involve doing research in reported incident like the one of Train Murder in 2004 which was committed by early discharged of psychiatric patient with diagnosis Schizophrenia from Ulevaal University hospital (UUH) that caused major conflict between UUH and Oslo municipal authority. That aim at uncovering the root cause, magnitude and measures of preventing such incidents from happening again. This is a typical example of lack of implementing clinical guidelines on discharge routines, and the problem falls under Intra-organization and Inter-organization problem of coordination.

5.3.3 The Earmarked State support

The earmarked state support for implementing nation mental health care programme, the policy is creating unnecessary accountability workload for health and social care sectors. The annual reporting form is complex and difficult to fill the reporting form, as such the DHSA is working to simplify the form to make the annual reporting easier for health and social care managers from both sectors. The DHSA is organizing leadership meetings, joint seminars and meeting with health social care professionals for common strategy and method for reporting and accounting for the earmarked grant. The DHSA has engaged both internal and external researcher like SINTEF- heath research organization to

investigate the problem in using this fund. The problem is the implementation difficulties related to delegated authority and policy coordination problem in bureaucratic model of professional organization.
Accordingly, my research study uncovered a number of coordination problems and challenges under the responsibility and authority of the Directorate. This includes among others, Problem in implementing National Health and Social Policy, Individual patient plan, which is a policy coordinating mechanism in the mental health care, quality control instruments like internal control, guidelines and routines, and Earmarked budget or State support grant, the Cooperation or Contract Agreement between hospitals and municipalities for the delivery of holistic and coordinated health and social care services for chronically sick patient including mental health care services. This policy rules and regulations do not work according to their plan intentions, and to mention as an example, the cooperation agreement between the RHEs and the municipalities created a grey area of legal responsibility over the group of patients who receive services across the levels of health and social care organization. The grey area means here that the areas of uncertainty as to who is legally responsible for delivery of some specified health care services to the patients or a disputed area of legal conflicts and responsibility over individual patient.

The disputes arise over economic responsibility for giving services like patient rehabilitation and follow up of individual patients when they have been discharged from the specialist hospitals, and send back to community care institutions in the municipalities. Under the Decentralization Act of health and social care services, the specialised health care services have responsibility and capacity of giving back up, when specialist competence is needed or specialised intervention (acute or not) is requested by primary health care institutions. The intention of the cooperation agreement is to ensure complete and coordinated HSCS to individual patients, good coordination and understanding between the parties involved in this agreement, and according to my informant the agreement is good for both parties, but its interpretation is what created the disagreement and conflicts between the two parties involved in this agreement. The dispute is caused between the two parties, because this agreement is open to different interpretations, giving way for the parties to the agreement to interpret the agreement according to what suits them, and taking care of their economic interests. Pushing the responsibility for the delivery of health care service from one party to another, and according to my informants, the dispute occur more often in the area of follow up and rehabilitation, after the discharge of patients from the hospital. This dispute affects the continuity of health and social care services to the concerned patients, and it also creates insecurity and uncertainty with the patient concerned, as to whether or not one will get the needed services that one has a right to and from where one will get them. These are serious questions for the patients concerned and their relatives. And it is in this kind of coordination problem where the health and social care directorate is implicated both directly and indirectly, because of it role and responsibility over cooperation agreement and because of its delegating authority over the regional and municipal health and social care institutions.

At the regional level, this cooperation agreement between the Regional Health Enterprise (RHE) did not include the General Practitioners (GPs), because the GPs are not parties to this agreement. As a result GPs role as patient coordinator, participation in the multidisciplinary organization like patient teamwork, network, individually patients group and so on is far less than other health care professionals. This affects the delivery of holistic and coordinated health and social care services to chronically sick mental health care patients. The lack of attendance from the side of GPs, affect the planning and accessing of health and social care plan for the individual patients. According to my research findings the reasons for lack of GPs participation in formal and informal multidisciplinary organizations were due to taking medical care of their patient in their list and other emergency needs of their patients, GPs have diverse and large number of patients on their lists, it varies between 500 to 1500 patients on average per GP in Eastern Regional Health Enterprise (ERHE). But the underlying reason is that the GPs are not parties to the cooperation agreement between the RHEs and the municipalities, and there are also reasons for economic incentives for GPs, According to my informants, who share this sentiment with many other GPs in the region, "although we get generous incentives for participating in multidisciplinary meetings, we lost a lot more by leaving our routine office work, and not attending for our regular patient care practices" said one of my informants.

The earmarked budget allocation for the escalation of the mental health care program, is also producing unintended effects. The management of the earmarked fund is increasing the bureaucratic workload, four times reporting obligation per year for the managers of this fund, the reporting forms are complex to fill, because of accounting challenges .The filling and completion of the requirements are time consuming, and it directs personal resources away from direct patient care. Here opinions are divided, though among my informants, however, the majority of them who have agreed that the four times reporting is indeed, causing administrative workloads for the managers. All of my informants appreciated the important contribution of the earmarked fund, but they all said the grant is not enough to cover the acute demand for housings for the users, and for meeting the ever increasing demand for personnel to work in the residential houses and institutions for the users, besides administrative workload the earmarked state grant is causing to the managers of this earmarked fund. The Directorate is responsible for the allocation of these fund to mental health care institutions across the two levels of health and social care organizations, and there by the consequences of this policy on the provision of health and social care services, and its effects on the affected patients.

5.4 Summary table of research findings

Secondary Health Care Organization	Primary Health Care Organization	Directorate of Health and Social Affairs	Inter-organization problems of coordination
-Organization and structural problems -Economic and resource problem -Capacity and skill personnel	• Organization, structure and Routine problem • Capacity, Competence, and personnel	-Problems in coordinating national health and social policy -Individual Patient plan -Problem of implementing soft policies or delegated laws, rules and regulations	• Policy implementation : Individual Patient Plan • Structure and Routine of cooperation • Communication and information problems
-Full implementations of National mental health policy, laws and regulations -Individual Patient Plan ((IPP) -Implementation of clinical guidelines and protocol	Economic and Resource problems • Earmarked state grants • Individual Patient Plan Contract and cooperation problems	-Imprecise laws and regulations -Problems of interpreting imprecise laws and regulations	• Economic and resource problems: Earmarked state grants • Capacity, Personnel and Competence
-Patient discharge routine, Patients follow up and rehabilitation	• Patients follow up and rehabilitation problems • Readmission problems of discharged patients	Problems of policy feedback and quality control	• Patients discharge routines • Patients follow up and rehabilitation problems
-Information and Communication Problems	• Housing and accommodation problems	-Economy and Earmarked state grants	• Contract or cooperation agreement
Contract and Cooperation problems	• Information and communication problems	-Information and Communication	• Problem of implementing and interpreting delegated laws and regulations

Chapter 6: Discussion

6.1 Individual Patient Plan (IPP)

It is a patient plan and patient rights which apply to all patients who are chronically sick or have health and social needs for long term, holistic and coordinated health and social care services from both specialist and primary health and social care organizations (Patient law: § 2.5). Individual plan is also a policy coordinating mechanism use by the Directorate of Health and Social Affairs (DHSA) to coordinate mental health care plan with primary and secondary health and social care sectors. My research study refers to it as policy coordinating mechanism in bureaucratic professional organizations from top to bottom policy coordination (H.Mintzberg). Individual plan is important for continuity of holistic and coordinated provision of health and social care services to mental care patients. It empowers patients by giving patient rights, information and influence in health decisions that affect their lives. My research study found out that the application of IPP is the main factor which is causing disagreement and conflicts between Primary Health and Social Care organization and Specialist Health and Social Care organizations, and the low quality of coordination of HSCS to mental health care patients.

According to my research findings, the following are the factors causing disagreements and conflicts between the PHSCS and the SHSCS and their effects on patients and the quality of coordination of health and social care services:
Unplanned patient discharge from the hospitals resulting in patients being discharged without medical records or reports, or poor information quality in the medical reports, or patient discharge without individual plan, and the concerned primary health care authority were not informed or involved in the process of individual plan, IPP sent via post received late or not received at all or primary health care authority were informed very late for make necessary preparation to receive the discharged patients, given two weeks notice to find accommodation, or patients with specialist health care needs are not follow up by the hospital authorities, GPs and nurses from the primary care sectors struggle to locate the missing information on patient journal or medical report by getting contacts with many instances in the absent of patient coordinator or responsible nurse in charge of the patient case .In cases of worsening patient medical condition after the discharged, readmission is not easy because of the capacity problem at acute department. These are difficulties and frustrations face by primary health care workers due to lack of coordination between the two sectors. While specialized authorities blaming the primary sector of negligence of duties and responsibilities, or lack of patients overviews and follow up or lack structure and routine of coordination and communication, because it is difficult to communicate patient information to their counter part in the primary care sector, due to difficulties in locating the person in charge of the patient, or the responsible person is not on duty or people do not take telephone, and the lack of contacts and communication is more common during the week-ends which is causing readmission problems because of lack of vacancies for the new comers and resulting in conflict, misunderstanding and lack of mutual thrust between the sectors, where each sector blaming the other for the problems of coordinating continuous and holistic individual patient plan as required by patient health law (chapt.on presentation of research finding).

My research study identified this kind of problems as the problems of patient supply logistics management.

The above research findings indicate the seriousness, and the challenges in coordinating holistic and coordinated health and social care services for mental health care patients. The questions my research study raised is what causes these problems, how does it affect patient health care plan and how does it affect mental health care policy of continuity, holistic and coordinated health and social care services between the levels of health and social care system (Research questions). The problems of unplanned patient discharged, lack of communication and cooperation and poor quality of information between the two sectors can be traced back to leadership and clinical management processes and patient supply logistics between the two organizations. According to mental health care Act, it is organization`s leadership responsibilities to ensure that long term mental health care patients with individual patient plan receive continuous, holistic and coordinated health and social care services without a gap in provision of care services between the health care levels and instances (IPP-guideline, IS-1013, 2001). These research findings are backed by secondary information provided by mental patient organization of Eastern Regional Health Enterprise (PPL-2007?). That mental patients feel the health care services they are getting is fragment, many people to be contacted between the levels, and are un certain about where the needed help will come from and when will they receive the services.

These expressions indicated the frustrations and sense of hopelessness among the mental care patients in getting needed health and social care services that they are entitled to. The patient feeling about the fragmentation and uncertainty of provision of health and social care services, which result to insecurity in service delivery that reduces patient chances for full recovery and rehabilitation. Because of lacking medical follow up from the concerned authority, patients do not stand a chance for full recovery or being rehabilitated into their communities. The lack of continuity and uncoordinated provision of health care services failed the goals of mental patient Act, and render the provision of health care services ineffective for this patient group, which has both social and economic effects for the affected patients, their relatives and hence the society. On the other hand the health and social care professional are not accepting the problems of health care coordination directly, they are saying that overload work because of few competence personnel to do the job, they are over stretched to the limit, they do not have sufficient time to do routine job, they work in hectic and contingence work program that is being interrupted all the time by emergencies situations, meaning the physician spent less time with patient and follow medical progress of the patient than is required.

The SHSCO do not have economic resources for employing more skilled personnel to solve the capacity problems that will reduce the coordinating challenges in patient clinical processes, like oversight with routine work lack of communication with external organizations and agencies, incomplete or unclear information and etc (presentation chapt.). My research study revealed that lack of resources can prevent coordination of health and social care services. However, increases in economic resource alone can not solve all the coordination problems within the sectors and in between them. But closure

cooperation between the two sectors like in joint patient follow up and rehabilitation projects, earlier involvement of the primary health care workers in the plan processes or clearer responsibility and role definition which can reduce conflict and misunderstandings between the two sectors, and therefore enhance cooperation and communication between the parties and improve the quality of coordinating continuity and holistic health and social care services in the mental health care sectors. And the realization of the goals and objectives of mental health care program which is commonly known as individual patient plan.

6.1 Patient Discharge routine

The patient clinical process in the hospital ends by implementing patient discharge routine which is a formal clinical protocol that end patient medical treatment process at the hospital, and is the last stage of patient clinical process in the hospital, and it marked the formal hand over and take over patient responsibility from one level to another or a connection point between primary and secondary health and social care services, for mental health care patient it is the point where individual plan process is finalised and handed over to the primary care authority, who take formal charge of the discharged patient and the responsibility of implementing the individual plant in closer collaboration with specialist health care institution. It is the process of individual plan that creates continuity and coordination of holistic health and social care services from one level or instance to another, the formal documents that link the two levels of health and social care organizations together are: Patient journal, patient medical report and patient individual plan, and the professional involve in the patient discharged process are physician in charge or patient coordinator, responsible for discharging the patient, at the present of patient`s GP, the two coordinators, responsible nurse and the relatives.

The patient discharge routine is a binding link between the PHSCS and SHSCS, it links the two levels of health care organization by communicating patient clinical process information, and by coordinating health and social care needs. Patient clinical process information is communicated between the two levels by medical journal and medical report, whereas health care services are coordinated by patient follow up and rehabilitation processes, clinical guidance, teaching and management and so on in the primary health care sector. The two health care levels are linked together and mutually dependence on each other by sharing patient information and experiences for giving efficient and effective medical treatment for the patients that get health and social care services across the two levels of health care organizations. Therefore good information, communication and coordination between the two levels of health and social care organizations is important for the continuity of health and social care services to this patient group. My research study revealed that patient discharge routine is causing disagreement and conflicts between the two health and social care organizations (Presentation of research findings chapt.). These problems include lack of patient discharge routine, communication and coordination and unclear or incomplete information in the medical journal and report and etc.

The lack of information is creating gap in the continuity of health and social care services to mental health care patients, reduces patient chances for recovery and rehabilitation, it delay the provision of needed health care services, and cause frustration among the health care workers at the primary health care sector and make the provision of health care services to mental health care patient ineffective. This is what my research study refers to as inter-organizational challenges of coordination. These challenges of coordination make the realization of objectives of mental health care act difficult and the patients and their relatives are paying absolute price for failure of coordination. Because of not receiving the health and social needs that they have rights to, and the patient chances for full recovery and rehabilitation into their community.

Although the inter-organizational problems of coordination, is caused by patient discharge routine at the clinical levels, but it is the responsibility of the leaders of the two sectors that bear ultimate responsibilities for the problems of coordination. It is the responsibility of institutions leaders to ensure that organizational policy and guidelines are fully implemented by the employees of the organization. Here procedures and clinical guidelines are not carried out as required by laws. The reasons for failed coordination is due to resource and capacity problems, the problem of lack of resources and capacity can not be solved by the organization employees, but can best be solved by the organization leadership. The organization leadership is responsible for securing needed resources and for employee sufficient staff to handle the given work task. It is for these reasons leaders are held responsible for inter-organizational problems of coordination between the two sectors. By enforcing clinical disciplines, teaching and training medical personal in the application and implementation of the clinical protocol, and by precision and simplification of the rules and regulations, will make the medical staff master the application and implantation clinical guidelines, rules and regulation which will in turn make the less expose to making routine era and thereby facilitating both internal and external coordination problems as reported by my informants. Clear task descriptions, role and responsible could also help a lot by removing uncertainties among the medical staff and thereby enhancing coordination and cooperation among the medical staff.

6.2 Cooperation Agreement

The Cooperation Agreement between Primary and secondary health and social care organization is established by health and social services laws §§ 1-4,6-2a that aimed at the provision of holistic and coordinated health and social care services to mental health care patient from the age of 18 year`s old and upwards. The cooperation agreement required the cooperation between primary and secondary health and social care organizations to ensure the continuity, holistic and coordinated provision of health care services to mental care patients, and it further encourage multidisciplinary cooperation between health and social care professionals across the two levels of health care organizations. The cooperation agreement is practice through the mental care act, which is also called individual patient plan (IPP) in mental health care services.

My research study revealed that the cooperation agreement between the two sectors is not achieving it objectives of continuity in the provision of health and social care services in a holistic and coordinated manner for mental health care patients. The agreement is

interpreted differently by the two parties, it did no include GPs one of the main partners of the primary care sectors, some local municipal administrative units have not yet signed the cooperation agreement with RHE, it does no give incentive to physicians for delivery of some services outside the hospital like follow up and rehabilitation of discharge patients and etc. The research study identified this as inter-organizational problem of cooperation as problem of implementing delegated rules and regulation in a bureaucratic model of organization (H.Mintzberg).

The GPs organization in the primary sector are not a party to the cooperation agreement, and therefore is not bound by the agreement, and have no attractive economic incentive for cooperation, the GPs loss more by participating in multidisciplinary teamwork as required by the cooperation agreement. Besides having long list of clients in their regular practices, emergencies situations do arise from time to time, therefore are over stretched and do not have capacity. This made GPs to participate less often in the multidisciplinary activities in the mental health care sector. The lack of GPs participation in multidisciplinary teamwork, affect the efficiency of team decisions on patient assessment and evaluation activities which is important for continuity of health and social care provision to patients with individual care plan. By not participating in the team meeting, this will affect the full implementation of individual patient plant, and thereby affecting patient chances of recovery and rehabilitation, because of the gaps in the health care delivery system between the two sectors. By including the GPs organization in the cooperation agreement, or by giving the GPs good incentive to cover their lost income due to participating in multidisciplinary meeting, will motivate them to participate more in the teamwork which will promote cooperation and coordination of comprehensive delivery of health and social care services which is good for patient recovery and rehabilitation and cost effective for the society.

In the primary heath care sector the health and social care authority have conflicts with the RHE over the implementation of the cooperation agreement, because of disagreement over responsibility of patient follow up and rehabilitation after discharged from the specialist hospital, dispute over discharge routine, premature patient discharge from the hospital and difficulties in readmitting earlier discharged patient (Presentation chapt.two). More often patients with treatment needs in the areas of specialised health care services are not receiving the health care services, because they discharged from the hospital, and therefore the follow up and rehabilitation lies in the hand of primary health care authority, even though the primary care sector do not have the competence and capacity to undertake such medical procedures. According to my research findings many discharged mental care patients with schizophrenia symptom, serious depression and etc redevelop the symptoms sometimes shortly after they are discharge from the specialist treatment and will require readmission to specialist hospital for further treatment. It is these kinds of situations which cause dispute between the primary and specialist health care authorities, and the resulting health problems for the patients, relatives and the society, in addition to frustration and difficulties caused to primary health and social care professionals. The dispute over service responsibility is a clear violation of patient rights to needed health and social care services, which is accorded in the following laws: patient health care law, health and social care laws and individual patient plan act § 6-2a and

RHE law § 41. My research study referred to it as grey areas of legal responsibility in the research findings presentation chapter. The conflicts between the primary and secondary health and social care authorities cause a gap in the continuity health care services between the two health care sectors, and hence achieving the main gaol of individual patient plan. The research study identified this problem as inter-organizational leaderships problem, it is the responsibility of the two health care authorities to cooperate with each other to avoid conflicts and enhance cooperation between them (H.Mintzberg).

While on the part of the Regional Health Enterprise (RHE) is that the primary health care authority is pushing their responsibility of patient follow up and rehabilitation over to the specialist health care authority, that patients are not discharged from the hospital prematurely, but patient discharge in accordance with clinical guidelines and medical practices, and that patient readmission is carried after the concerned patients fulfil readmission standard. By denying their responsibility over the discharged patients, primary care authority causing vacancies problem for admitting acute patients and those who are in a waiting lists, which is causing frustration and capacity problems by keeping medically discharged patients in the hospitals waiting to be received by primary care authority. And by performing the role and functions of primary health care organization, the specialist health care professionals are not economically rewarded for the work done on behalf of primary health care authority. My research findings identified the problem of health care coordination between the two sectors as the problem of patient supply logistics (J.Øvretveit). While H.Mintzberg, refers to it as problem of process production management.

While the central health and social care authority, share collective responsibility for making the implementation of delegated health policy difficult to the primary and specialist health and social care authority, and the consequence of failed policy coordinating mechanisms which is individual plan, the two sectors and the mental health care patient who are directly affected by unclear role and responsibility between the parties to the cooperation agreement. The conflict caused by cooperation agreement is affecting patient health care plans, the efficiency and effectiveness of providing holistic and coordinated health and social care services to individual mental care patients according to mental health care act or individual patient plan (IPP), and according to my research study the problem is connected to implementing the delegated policy from the top to bottom in hierarchical order of bureaucracy (H.Mintzberg).

6.3 Earmarked State Grant

Earmarked State Grant is State financial support to primary and secondary health care sectors to finance mental health care reform which started in 1999 and scheduled to end in 2008. The purpose of the State grant is for capacity building and increase competence in the mental health care sector, the Earmarked grant is provided and controlled by the Directorate of Health and Social Affairs (DHSA). The DHSA provides the earmarked funds for coordinating individual health care plan in mental health care sector. Individual health care plan which is a policy coordinating mechanism in mental health care sector, my research study revealed that the use of the earmarked grants is producing negative

effects, which is contrary to the purposes of allocating the funds to the mental health care organizations. “Accountability and reporting for the earmarked funds creating workloads for mental health care managers, because of reporting problems and the complexity of filling reporting forms, it requires a lot of time and resources, and deviating time and resources away from direct patients care services as reported by the research findings”. My research study referred to these problems as the problem of implementing and coordinating organization policy from top to bottom model of professional bureaucratic organization (H.Mintzberg).

The administrative cost of earmarked fund is taking many useful hours away from direct patient care services, because reporting is preconditioned for granting the fund, it mean health care manager set higher priority for reporting than direct patient care services. This will under mind the work of patient follow up and rehabilitation processes, this will further effect the coordination of individual patient plan and the efficiency of the fund in coordinating mental health care policy and hence increasing capacity and competency in the sector. The research study revealed that the administration of these funds is causing frustration among the health care managers, because of having a few skilled personnel to do both clinical and administrative duties in the sectors, which increases workload and eventually will affect the quality of providing holistic and coordinated health and social care services in the sectors. This is because of prioritizing administrative work of earmarked grants at the expense of direct patient health care services, the health care managers are doing so with the aim of getting continuous state financial support which is necessary for running escalating mental health care program. All my informants have agreed about the logic of reporting and accounting for the use of the fund, but have difficulties in meeting the four times reporting schedules per year, because of the complexity of filling the forms which is time consuming and difficult as reported by my informants (research findings). The informants are of the same view that the reporting forms should be simplified and the reporting schedules should be reduced, as this will give them more time for clinical management.

6.4 Coordination and Communication

Coordination and communication are closely related strategies which health and social care managers link together the various people, divisions and units within their organization and link their organization to other organizations and agencies. The importance of coordination and communication is an appreciation of the high level of interdependence shown by health care organizations. Interdependencies exist in both their internal structure and external relationships. This is because health care organizations have become very complex internally and have established a wide variety of external relationships for maintaining effective
Interconnection (Chan &Tewksbury,1993 or HCM, 2000,Ref:chapt.2 on theory). My research study revealed that coordination and communication pose a great challenge in the delivery of complete and coordinated health and social care services for chronically ill mental care patients.

These challenges are caused by incomplete or unclear information in patient medical journal and medical report, premature patient discharge, patients discharged from the

psychiatric department without carrying medical report or medical report delay, patients discharged without informing primary health care authorities or their relatives, it is difficult for health personnel in the primary sector to inquire patient information from the hospital, difficult to establish contact with patient coordinator in the hospitals. While on the hospital side is complaining of difficulties in establishing contact with relevant person in the primary health care sector, responsible personnel are not available in times of contact. My research study revealed that both the primary and secondary sector push responsibility from one sector to another. As the two sectors are mutually dependence on good patient information and at a needed time to continue with the delivery of services to the concerned patient, therefore lack of necessary patient information, or late information creates gaps in the continuity of health and social care services to the patient. This will affect effectiveness and quality of HSCS and will thereby reducing the chances for patient full recovery and rehabilitation. The question my research study raised is how the problems of coordination and communication affected the two sectors and how do these problems affect mental health care plans. What are the consequences to the mental health care patients (Ref.Research questions). And how can these problems are solved by the central authorities.

The impact of lack of information and coordination is greatest at the entrance points into the two sectors which the clinical patient pathways model refers to as Stage 1, that is at the point of referral by GPs or Patient self-referral to the specialised health care services (pp 2.2) or (pp 2.1) entrance to primary care sector after patient discharged from the hospital at the point of referral and reception. The lack of patient information or unclear patient journal from GPs will delay patient accessment and admission processes, and thereby resulting to delay in patient treatment process. This will increase extra-workload to the admitting hospital staff by starting the admission process from point zero, where the patient has no relevant medical record. Besides, this will cause frustration for health care personnel, long time in patient assessment and admission process, lack of confidence in the work of each other and reducing patient chances for getting effective treatment. The ultimate victim of the lack of coordination and information from the either sectors is the patient who depends on effective and speedy clinical process from one stage to another and from one level of health and social care organization to another in a continuous and coordinated manner. As my research study revealed that patient are frustrated, and feel that HSCS are fragmented and that they are not getting the services that they have rights to and have deserved them.

The problem of communication and information management affect the quality and efficiency in the delivery of health and social care services to the mental care patients as revealed my research finding. The lack of reliable information between the health care organizations, creates gap in the continuity and comprehensiveness in the delivery of health care services, due to lack of sufficient information for starting to implement individual patient plan. The clear testimony to the problems are seen by the frustration expressed by health care workers and the uncertainties express by the patients over the delivery of complete and coordinated health care services which they are entitled to (research findings). The lack of communication and poor quality of information exchange between the two sectors prevent the continuity and coordinating the holistic health social

care services to the patients, and hence prevent the achievement of the goals and objectives of individual patient plan and denying the affected patients the chances to recovery and rehabilitation and is costing economically a lot to the society.

From the informants perspectives, the communication and coordination challenges between the two sectors can best be minimized by the collaboration between the two sectors closely, by holding regular leadership contacts between the two sector, by encouraging parallel inter-professional contacts, establishment of joint coordination forum, increasing regular contacts at the lower levels of the two sector, which reduce un necessary contacts with irrelevant instances and personnel, that further result to ineffective use of time and personnel resources. There is also need for clearer definitions of roles and responsibilities of the individual office holders, and making the employees aware of their own role and responsibility, besides the other health and social care workers. As this will enhance dialogue, cooperation, understanding and mutual confidence and respect among the various professional groupings, which lead to better coordination of health and social care services to the mental patients.

6.5 Economy and Resource problems

Economy is a factor of production an organization employed to realise its gaols and objectives. Health and social care organization like any other production enterprise rely heavily on economic resource to pay for production factors like skilled labour force, health care technologies, rent and transportation and etc. Which are necessary resources for running health and social care organizations, my research study found out that economy is one of the main factors causing coordination and cooperation problems between the primary and secondary health and social care organizations. It is hindering the full implementation of clinical guidelines, competencies and capacity, and individual plan in the mental health care services, and therefore the goal of implementing holistic and coordinated health and social care services in the mental health care sector.

My research study revealed that economic factor is the reason for not employing enough skilled personnel in the health sectors, which result to staff over stretch and working overload in the health care sector, limited time to perform routine duties, and capacity problem in operating technical systems. Earmarked state financial grant is not sufficient for training and employment in the mental health care sector, and in order to continue getting state grant, health care manager use a lot of time in reporting and accountability for the funds and deviating time and resources away from direct patient care services. The conflicts between the primary and secondary health and social care organizations over discharged patient follow up and rehabilitation is also caused by economic responsibility for giving health and social care services to discharge patients. Each party avoid taking patient responsibility on the ground of competence or capacity problem, but the underlying reason for the denying patient responsibility is mainly economic factors. Although the primary and secondary health and social care laws made clear the role and function of the two levels of health and social care organizations. Under the decentralization policy, the secondary or specialised health care institutions have the responsibility and capacity for giving back up, when specialized competence is needed,

or specialized intervention of acute or not is requested by primary health and social care authority (§§ 2,2-5). My research findings refers to this coordination problem as “the two parties interpret the cooperation agreement according to what take care of their economic interest” in the presentation of my research findings. Where as, my research study identified, this problem as the problem of implementing the delegated authority from top to bottom in a bureaucratic organization (H.Mintzberg).

The disagreements and conflicts between the primary and secondary health care authorities under mind the mental health care policy of continuity, holistic and coordinated health care services mental care patients. The dispute between the two health care authorities as to who is responsible for giving health care services, postpone or delay the delivery of much needed health care services to the concerned patients. The economic responsibility also make the specialists select the type of services that can be delivered to discharge patients which result to partial delivery of services as oppose to holistic and coordinated health and social care services. Because they are not pay for rendering sone services to the primary sector, the specialist are paid according to Diagnosis Related disease Group, abbreviated as DGR, therefore any health care services falling out side the DRG system is not paid for by the health by the health care authority, and hence this restrict their service delivery to the primary care sector, especially in the areas of patient follow up and rehabilitation. This is seen from the perspective of primary care sector as being selective in the delivery of health care services. My research study revealed further that GPs participate rarely in multidisciplinary teamwork is because they lost a lot economically by participating in such a meeting, this under minds the multidisciplinary teamwork and affect the continuity and coordination of comprehensive health and social care services. The restriction in the extend of specialist health care services to primary health care sector, and the GPs lack of insufficient economic incentives for taking part in multidisciplinary teamwork, underscored the importance of economic resource in the coordination of holistic and continuous delivery of health care services in the health and social care organization. The disputes between the two health care authorities make patient follow up and rehabilitation ineffective, and is economically costing a lot to the patients, relative and hence the society, as referred to by my research motivation.

According to my informants the economic issue revealed here is not properly address by the cooperation agreement between the primary and secondary health and social care organization and is among others hindering the continuity and coordination of holistic health and social care services between the two levels of health care system. Addressing the economic issue revealed by the research findings, will enhance health and social care service collaboration, and thereby enhancing coordination of holistic health care services in the mental health care sectors, by encouraging cooperation, understanding, respect, mutual trust, communication and thereby reducing inter-organizational conflicts between the health and social care sectors. Besides the economic resource is important for personnel learning and training that will lead to capacity and competence building in the two sectors, which is important for coordinating health and social care services in the two health care sectors.

Chapter 7: Conclusion

7.0 Concluding Remarks

My research study found out that economic factor is one of the major challenges to continuity, and provision of holistic and coordinated health and social care services for long term mental care patients between the levels of health and social care system. It is behind the acute demand for health care personnel, competence and capacity problems in the two health care sectors. It contributed also much to the conflicts and disagreement between the primary and secondary health care organizations that affecting the continuity and comprehensive delivery of health and social care services. The sighted example of this is shown in the conflicts between the two health care sectors over the discharged patients follow up and rehabilitation. The economical factor is causing rivalry and competition among the health care organizations, which affect economic resource allocation, thereby affecting the quality of provision of health social care services in the mental health sectors, as the research findings revealed.

Therefore a unify goal, culture and cooperation is needed in the health and social care sector to overcome the challenges. There is need for increased economic resource allocation in the sectors, however, this should go hand in hand with more resource control, responsibility and accountability for health care managers, avoiding the effects of deviating resources away from direct patient care services as revealed in earmarked state grants. There is need for clearer and more precise definitions of roles and responsibilities of various office holders in the health and social care organizations. This will reduce communication and information problems between the health care organizations, as shown in the discussions.

The challenges of implementing policies delegated from above in health care organizations is to make the rules and regulations more precise so as to prevent misunderstanding and misinterpretations by the health and social care authorities. Although the division of roles and responsibilities are clear, there is no clear cut demarcation in the roles and responsibilities the two organizations, there are loopholes in interpreting the laws rules and regulations, resulting to different interpretations of the laws and regulations by health care authorities that causes conflicts and disagreements between the parties. This affects patients recovery, follow up and rehabilitation and making the delivery of health and social care services less economical effective.

Therefore, to reduce the challenges in coordinating health care services, the ambiguities in interpreting the cooperation agreement between the parties have to be removed by making the laws simpler and more precise that will avoid different interpretation, conflict, disagreement and enhance cooperation and communication among the parties. Through inter-organizational cooperation, the two sectors can participate in a joint project, like joint patient follow up and rehabilitation project, inter-professional communication and coordination by sharing patient information. The enhanced cooperation will close the service gaps, sectors fragmentation, and will improve coordination and communication in the delivery of health and social care services for the

benefit of individual patients. The enhanced cooperation will improve health care service which is good for the society and social welfare state.

There are organizational and structural problems in both the primary and secondary health care organizations, which is causing the problem of service coordination and integration. It creates communication barriers due to lost information, cultural difference, conflict and rivalries between organization and divisions, there is need to make organization structure flat, as this will facilitate communication, cooperation and coordination.

7.1 Conclusions

The conclusions of my research study is that there are organizational and structural problems in both the primary and secondary health care organizations, which is hampering the coordination of health and social care services in the mental health care sectors. There is problem in coordinating national health policy, in the areas of implementing delegated laws, rules and regulations at the primary and secondary health and social care levels, and among others the cooperation agreement and the professional guidelines do not promote coordination of health care services, due to interpretation and implementation problems. There is also communication problem between the two levels of health care organizations, because of information gaps which result to misunderstanding, uncertainty and conflict between the two organizations. The mental health care is under-funded and is causing capacity and competency problems, which is making the realization of goals and objectives of individual patient plan slow and difficult, because of economic and resource problems. Therefore more funding is needed in the sectors to alleviate the problems of competency and capacity, and this will reducing economically related inter-organizational conflicts, enhances cooperation and coordination of health care services.

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Appendices
Part 1: Interview Guides for the Research Project
1.0 To Directorate of Health and Social Affairs

The interview guides for the research project

"At the hospital levels, DPC, and Primary Health Social care Institutions, the National Mental Programme requires cooperation, communication and coordination, and formation of multidisciplinary teamwork with different organizations and Professional groups to work together for delivery of complete and Coordinated Health and Social care services at institutional levels and at the individual patient level with the aim of ensuring continuity of delivery Health and Social care Services to mental health care patients" (Escalation of Mental Health Care Program 1999 – 2008). How does this reality and complexity pose a challenge to the coordination of Health and Social care services as required by Mental Health Programme (NOU:2004:18 and NOU:2005:3).

- How does this reality pose a challenge to National mental health program in the field of cooperation, communication and coordination of a complete health and social services to the mental patients?
- What is the National Plan for cooperation and coordination of Mental Health care Services? What does the Directorate do to ensure coordination at the operational level?
- What is the responsibility of the Directorate when it comes to coordinating services for… patients? How have the Directorate and other national agencies delegated coordinating functions to local administrative and clinical actors? How precise is this delegation?
- How does the Directorate carry out its coordinating policies in the area of psychiatric health care?
- To which extent, and how, are the effects of the policy of coordination evaluated by the Directorate, or other national agencies?
- Does the Directorate have plans to step up its efforts to improve the coordination of psychiatric care?
- What is your opinion on the implementation of mental health care plan?

1.1 To the Specialist Health Care Organizations

To the Specialised Health and Social care Services (Hospitals, DPC, GP and Coordinators): Interview Content/Statement

"At the hospital levels, DPC, and Primary Health Social care Institutions, the National Mental Programme requires cooperation, communication and coordination, and formation of multidisciplinary teamwork with different organizations and Professional groups to work together for delivery of complete and Coordinated Health and Social care

services at institutional levels and at the individual patient level with the aim of ensuring continuity of delivery Health and Social care Services to mental health care patients" (Escalation of Mental Health Care Program 1999 – 2008). How does this reality and complexity pose a challenge to the coordination of Health and Social care services as required by Mental Health Programme (NOU:2004:18 and NOU:2005:3).

Check list questions:

- What is Hospital plan for cooperation and coordination Mental Health care Services?
- How do the hospitals and other national health care agencies delegated coordinating functions to local administrative and clinical actors?
- How precise is this delegated policy? How does the hospital implement the delegated policy from the DHSA to ensure coordination at the operational level?
- Who is responsible and accountable for the coordination of services to patients?
- What is the method of cooperation and coordination?
- How is Health and Social care Service for the Schizophrenia patients coordinated between health care providers and agencies?
- What are advantages and disadvantages of coordination of services in this way?
- How effective is National Mental Health Plan, in relation to coordination, follow up capacity and individual plan for patients?
- What is your opinion on this National Health Plan?

Questions list to Specialist health Care Services:

How is the hospital care services organized? What is the intra and inter-organizational structures of communication, coordination and communication? What are the problems and challenges of organizing in this way? Who is responsible for service cooperation and coordination?

What is the discharged routine for patients with individual plan?

What is your responsibility to the discharged patient?

What are the formalities for discharge procedures?

How do you follow up patients after their discharged?

When is formal patient responsibility transfer from SHSCS to PHSCS, what are the problems and challenges connected to the transfer of responsibility from one level to another?

What are the challenges and problems connected to patient discharge procedures?

What are the problems and challenges for continuity and coordination of HSCS to patient with individual plan?

What are the cooperation problems and challenges in connection with patient discharge routine?

How do you resolve these problems?

What are the challenges and problems of cooperation between the health care service providers?

What is your opinion on the challenges of cooperation and coordination of mental health care services?

1.2 Primary Health and Social Care Services (PHSCS)

"At the hospital levels, DPC, and Primary Health Social care Institutions, the National Mental Programme requires cooperation, communication and coordination, and formation of multidisciplinary teamwork with different organizations and Professional groups to work together for delivery of complete and Coordinated Health and Social care services at institutional levels and at the individual patient level with the aim of ensuring continuity of delivery Health and Social care Services to mental health care patients" (Escalation of Mental Health Care Program 1999 – 2008). How does this reality and complexity pose a challenge to the coordination of Health and Social care services as required by Mental Health Programme (NOU:2004:18 and NOU:2005:3).

Checklist questions:

What is the structure of your service organization?

What is the structure of your cooperation and coordination?

Who is responsible for cooperation and coordination?

Who is responsible for mental health and social care services in the county and municipality?

What are the problems and challenges in mental health care services?

How do you resolve these problems and challenges?

How clear is the responsibility defined between the parties?

What are the problems and challenges of the service organization in this way?

What are the problems and challenges in implementing individual patient plan?

What is your opinion on the problems and challenges mental health care services in the county/municipality?

Table of the Interviews Lists

3. 2.1 Directorate of Health and Social Affairs

Institution	Position of interviewee	
Directorate of health	Senior policy adviser	

3. 2.2 Regional Health Enterprises:

3. 2.3 Aker University Hospital

Institution	Interviewees positions	Names	Contact Information
Aker University Hospital	GPs representive/Patient Coordinator		
Follo DPC	Division chief		
Follo DPC	Sector Coordinator		

Akerhus University Hospital

Akerhus University Hospital	Position of interviewees		
Department of Mental Health	Director of the mental Department		
Psychiatric Department	Clinical Chief		

Ulevaal University Hospital

Institution	Position of		

	interviewee		
Ulevaal University Hospital	Patient Coordinator		

The list of the informants from the primary health and social care institutions

Institutions	Position of interviewees		
Bydel Søndre Nordstrand	Psychiatric Sector Coordinator		
Langerud Nursing Home and Rehabilitation	Chief Nurse		
Bydel Alna	Psychiatric Sector Coordinator		

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Short summary of my research findings

The summary of this preliminary report is based on interviews and documents collected from the informants. These are the sources of the summary: Primary health care organizations: Anya Johannessen: psychiatric sector coordinator, Bydel Søndre Nordstrand, Astrid.S.Madsen area coordinator Ski district, Torid Mood: Head nurse Langerud nursing home and rehabilitation institution, Østensjø bydel, Solveig Røthe: Sector coordinator, Alna bydel and two district medical officers.

Specialised health care institution: Trond Rangnes: Director dept. psychiatry AHUS, Sur Seim: Chief of clinical dept. psychiatry division AHUS, Bente Thorsen: GPs representative and patients coordinator AUS, Klara Nordhaug: Leader Follo DPC/ Ski county, Tove Gundersen: Patient coordinator UUS, Jan Tvedt: Senior adviser: Dept. mental health SHDir., Jon Storaas: Head of patient representative, health enterprise eastern region (information on mental patient experiences from the whole eastern region (altogether 8 hours audio recorded interviews on cassette).

The summary of research findings on coordination challenges between Primary health care services and Specialise health care services as seen from the Primary health care perspectives:

Primary health care institutions

Intra organizational challenges to coordination of primary health care services, my research study revealed that there is no formal structure of communication and coordination in the municipalities, various unit operate independently. Resulting to fragemented or partial delivery health care services and unnecessary delay in delivery of services to patients.

There are formal structures of coordination at organizational leadership levels (personal representation). At individual patient level (individual plan), there is no or limited structural support to ensure complete, continuity and coordinated health and social services. This is creating frustrations among the health and social care personnel, and that services to patients are not jointly integrated because of lack of coordination (specific problem and examples). The lack of coordination is due to organizational, structural and routine problem. There is no common forum of coordinating services to individual patient, although some patients have patient coordinator. Complete and coordinated follow up is lacking for patient (different service providers act independently without consulting other providers/agencies, as a result mental patients have difficulties, uncertainties and frustration over the service provisions.

Patient follow up and Rehabilitation:

Is difficult or insufficient because of a few competent personnel, lack financial resources, capacity, and have a few alternatives, where there are few services on offer and high demand for services and coordination and cooperation problems with the specialist health care organizations.

Accommodation:

There is acute demand of housing for psychiatric patients in the county and municipality, I had visited some of the municipality buy accommodation facility from their neibours as alternative for accommodating patients from other counties. The reason for accommodation problem is due to limited fund for housing, personal and competency to work in the houses (nurses/auxiliary nurses, psychologist, psychiatrist, social worker etc). The number of discharge patients, from the hospital and long term mental health care institutions overwhelm the municipal capacity. There is also problem with hospital discharge routine, insufficient information and cooperation between the parties. Short notice is given to acquire accommodation for mental patients.

Economy:

There is little funds for employment and capacity building in the sector, the earmarked state grant is no sufficient, there is also problem with the four times reporting per year. As a result

There is little funds for housing and personnel assistant in the houses. There is little increment in the earmarked budget, despite the ever increasing demand of mental health care services in the municipalities.

Inter-organizational problems in primary health care services:

Individual plan

- mental pasient are discharged prematurely from the hospital, Primary health authority more often given short notice from the hospital. Patient release without individual plan in place which result in dispute and disagreement between hospital and the community care authority. Lack of communication and coordination between the two parties, through phone, lack of medical report or incomplete, lacking detail (unanimous and confidentiality), this medical report comes normally late. Because of confidentiality, it is difficult for nurses and other health personal to get information from the hospital at the time of need. I t is difficult to get contact with patient coordinator/doctor in charge of patient, this is creating difficulties to health personal and delivery of care services.
- Disagreement over patient responsibility after discharged from the hospital which is the boarder line of obligation, role and responsibility between the parties, particularly in the area of patient follow up and rehabilitation. The Primary health authority lack capacity, competency and personnel to handle the so called "Difficult and heavy" patient group. Patient readmission is difficult, and it take a long time to get readmission in the acute psychiatric department, due to disagreement, capacity and low priority for readmitting mental patient.
- Accommodation: Unplan and premature discharge from hospital and other psychiatry institutions create housing and capacity problems.
- Economy: There are disagreement between the two parties as to who is responsible to cover the bill for patient follow up and rehabilitation services.
- Organization structure: (District medical officer, personal doctor and intake office(local administration) on one hand and (Hospital,DPC and long term institutions) on the other hand there is gap in the two way information flow systems, cooperation and there is routine and follow up problems between the two health care sectors.

Specialised health care institutions

Specialised health care services (AHUS, AUS and UUS and their respective DPC)

Intra-organizational coordination challenges:

- Organization: Hospital psychiatry department and DPC are situated in different geographical locations and far from each other, the same organization with the DPCs is located far from each other in different locality. This creates leadership and administrative problems: Communication: physical contacts among top management is not frequent, and have to be planned in advance, there is barrier to communication because of long distance between hospital and DPCs. Cultural differences and competition between the units, there is also inter-professional rivalry among the units. Organizational staff meetings at lower levels are rare. Emergency and crisis meeting take time for coordination. Economic incentives to attract employees in some DPCs location creates conflict.

- Medical report, Patient coordinator, or the responsible doctor changes when patient get transferred from one department to another and from department to DPCs, this creates work loads of intra-organizational follow up and coordination. The frequent changes in patient coordinator and together with workload of physician may lead to information gap between the stages of clinical processes.Writing medical journal and report is difficult and complex business and it takes time to write one report. It is to be communicated, coordinated and follow up (Intra/inter-coordination problems) causing communication and information gap. There are limitations in getting sufficient skilled personal to operate and run the system. There are also capacity and resource problem.

Inter-organizational challenges:

Patients Discharge Routine:

- Patient journal and medical report: It takes long time to prepare, write and send patient medical journal and report. There are many waiting acute patient to attend to, little time to write medical report, demand for work load overwhelm available doctors. As a result medical records send often late to primary health care institutions, the content of lesser information or missing relevant information than is required by patient law. Medical report is send more often to patient doctor than to other primary health care institution where it is most need like intake office, sector coordinator, nursing home or long term care institutions in the counties. The average time for receiving medical report is between one week to two weeks, and in extreme cases, it can take up to one month after patient discharged from the hospital.

Individual patient plan:
- Common system era: Patient is discharged from hospital without individual plan, individual plan is posted via ordinary mailing system. Some patient comes with individual plan in pocket, medical journal and medical report come at the same time (A- and B-forms). Local medical authority is more often not involved in the process of individual plan or get involved at the final stage.

Capacity problem:

- The acute psychiatry department have capacity problem in terms of available hospital beds and lack of skilled medical staffs. As a result, it is difficult for patient to be admitted or readmitted in the acute department.

Patient follow up and rehabilitation after discharged from hospital:

- The obligation, role and responsibility of the hospital over patient out side hospital is determined by the following laws: Primary health care law: § 6-2a, Specialised health care law: § 2-5, Social care law: § 4-3a and Patient law: § 1-3. These laws are interpreted by the parties involved with the delivery of social and health care services in the way that them. These laws are open, un precise and giving ways of different interpretation by the parties involved. It is a main factor behind inter- organizational conflict between primary and secondary health care institutions.

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Communication problems:

- Medium of communication between specialised health care and primary health care institutions : Internet, Telefax, Telephone and mailbox posting

- Internet communication: The two levels of institutions in the same health care system, use different communication systems and model. The two model of communication use different software system and the two systems are not integrated. Contact points/contact person, telephone, telefax and mail delivery systems have their respective weaknesses and strengths in the national health care system.

- Forum of coordination: Relevant ones: Inter-organization leadership meetings one/twice a year, rare emergency meetings, seminars and courses, and medium and lower level leadership meetings and multidisciplinary meetings like teamwork, Patient responsibility group meeting, inter-professional meetings, these have their specific weaknesses and strengths in the light of health care coordination.
- Economic and resource problems: There is lack of fund for building and increasing capacity in the sector. The demand for mental care service is growing year by year, whereas the increase in the annual budget does not match the service demand.

Directorate of Health and Social Affairs

The Directorate of Health and Social Affairs (DHSA) is responsible for the overall coordination of national health and social care policies. The DHSA do so by health and social care services guidelines, laws, rules andregulations, contract or cooperation agreement between primary and secondary health and social care organizations, cooperation project and through earmarked state grants. The challenges to the DHSA is lack of direct control over the implementation of the delegated, policy,laws, rules and regulations. As my informant state that the have problem of controlling soft policy or delegated policy mechanisms, which is very slow and unsystematic and sometime unreliable about the real implementation of policies and their effects. For the quality control the directorate rely upon their medical officers in the counties and the municipalities, health signal from the public, research reporting and from their partners in other national health and social care institutions for examples universities, Public health institute and the Board of health etc. But more often these health report take time to come out, it need further research into the problem areas to identify and confirm the problems. It is not as quick as they would like to control and the control is no systematic. The general impression from my informant was that the health care system is not working perfectly as they would like it to be, “ We have a mixed filling, the quality control is far from perfect, or systematic, there is stilled a lot to be done to improve the health care system, but we are in a right trek with the effort which is being made in that regards” end

the quotation. And with more cooperation between the parties, more control and follow up, the plan introduction of DRG-system in the primary health care sector, change of attitude, culture will lead to mutual respect between the parties and will lead to improvement opportunity in the health and social care services.