

# Implementation of the Municipal Emergency Day Care Unit in Oslo

Irvinas Kairys



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Irvinas Kairys

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<http://www.duo.uio.no>

University of Oslo

# ABSTRACT

**BACKGROUND:** The implementation of the Coordination Reform (Helse- og omsorgsdepartementet, 2009) started in 2012. One of the reform's goals is to establish municipal emergency day care units (*Kommunal akutt døgnet*) (hereinafter – KAD<sup>1</sup>) that cover the needs of local population in municipalities. Establishment of these units is underway now or is due for completion by the year 2016. However, Oslo fully established these services in 2013 and it will be taken as a case for the research.

**OBJECTIVE:** To examine if the implementation of the KAD in Oslo has proceeded as intended. GPs' referrals to Oslo KAD are given primary focus in the research because one of the Coordination reform's goals is to reduce admissions to specialized healthcare services. More specifically, in this research I aim to understand what factors of low referral rates to Oslo KAD are as well as to compare these findings with the research results obtained from relevant staff members of Oslo KAD. Analysis of the results through implementation theory will help to explain the gap between intended and implemented KAD in Oslo.

**METHOD:** Statistics from Oslo KAD showed that general practitioners avoid referring patients to this institution, choosing instead hospitals. Semi-structured interviews were used to examine the implementation of the Oslo KAD from this point of view. Sample in this single case study includes general practitioners in Oslo municipality, Oslo KAD and staff from emergency ward in Oslo. The data were analysed using the qualitative data analysis method by analyzing content and discussed from the Implementation theory perspective.

**RESULTS:** The findings of the research have shown that the main factors behind the bottlenecks to implement the KAD as intended are differences between healthcare organization in Oslo in relation to the rest of Norway; challenges of providing information for GPs; logistical issues; and novelty of the Oslo KAD. The results were discussed based on implementation theory.

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<sup>1</sup> KAD – (*Kommunal akutt døgnet*) - is a common abbreviation in Norwegian documents, legal acts, reports and other materials. There being no commonly accepted English abbreviation, the abbreviation 'KAD' will be used hereinafter for the accuracy purposes.

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## **Abbreviations**

KAD – municipal emergency day care units (in Norwegian: *Kommunal akutt døgnet*)

GP – General practitioner (in Norwegian: *fastlege*)

# 1 Introduction

The Coordination Reform is the latest major healthcare reform in Norway. In addition to being a healthcare reform, it is also an administrative reform due to the transfer of health services from the state to municipalities. In practice this means that local authorities must take over part of the responsibilities for treatment of patients. In addition to responsibility for ready to be discharged patients from day one and municipal co-financing, municipalities, by 1<sup>st</sup> January 2016, will have established municipal emergency day care services that cover the needs of local populations. The costs of establishing and operating these services are estimated at NOK 1,048 million per annum as of 2016 (in 2012 prices) (Baaske, Bringedal, Halvorsen, & Torgersen, 2013). These costs for municipalities are fully funded through the transfer of funds from health authorities. Also, it is assumed that a quarter of the Norwegian municipalities will establish these services on a yearly basis in the period 2012-2015. At a starting point within this four year period municipalities will receive one half of the funding from the Norwegian Directorate of Health and the other half from the health authority when the KAD is fully established. It is intended that the funds will be entirely incorporated into block grants to municipalities starting with the year 2016 (Baaske, Bringedal, Halvorsen, & Torgersen, 2013).

As of yet, few studies have been made regarding the municipal emergency day care units. Several reports evaluating the development of KADs have been published on municipal and state level. While municipal level reports could be used for comparison purposes, reports covering all Norway (Baaske, Bringedal, Halvorsen, & Torgersen, 2013; Snøfugl, 2013) in particular are focused on a general quantitative overview of the situation that should be in place by the year 2016. This leaves some unfilled gaps on qualitative basis regarding the implementation of the KADs in Norway.

In this study I will fill one of these gaps and explain the implementation in terms of referrals to the Oslo KAD by general practitioners in Oslo. From the statistical data obtained from the Oslo KAD regarding referrals from the GPs I have learned that the GP referral rates were low comparing with other municipalities in Norway. I asked my self the question why it is so? To understand this I want to explore the factors which could be related with low referral rates from GPs to Oslo KAD. Content analysis of interviews and the results discussion through implementation theory will help me to explain the gap between intended and implemented

KAD. The research question of this thesis is as follows: “Has the implementation of the KAD in Oslo proceeded as planned?”

The hypothesis of the research could be denoted as follows: There are factors common for relevant stakeholders in Oslo which challenge the implementation of the Oslo KAD.

The variation, tendencies and attitudes related to the patients’ referrals and in general to the KAD as a concept will be evaluated by performing qualitative content analysis of the semi-structured interviews. Insights, attitudes, personal opinions of respondents based on their work practice will be taken for consideration and evaluation in this process using the Theory of Implementation.

## **1.1 General practitioners and referrals to the Oslo municipal emergency day care unit**

Oslo is among the municipalities, which have opened the municipal emergency day care unit in 2013. This unit is established at Aker Hospital. The localization is a result of the council's desire to make provision in connection with the emergency services and the establishment of the Coordination Arena Aker. The process has been developed in cooperation between hospitals in Oslo, city districts, governing mayors in the various districts of the city and the South-Eastern regional health authority (Baaske, Bringedal, Halvorsen, & Torgersen, 2013). The establishment of the municipal emergency day care unit in Oslo has been conducted in three stages: 1) investigation of services to be offered; 2) development of partnership and cooperation with hospitals, and 3) involving a mapping process in cooperation with hospitals, emergency rooms of hospitals as well as observation posts and paramedics regarding the patient groups which should be considered for services in the Oslo KAD (Baaske, Bringedal, Halvorsen, & Torgersen, 2013, pp. 53-54). The KAD was opened on the 17<sup>th</sup> June 2013 with 10 beds available for admission (Oslo kommune, 2011). The number of beds available will increase to a total number of 73 beds over 2014 (Oslo kommune, 2011).

The goal of the Oslo KAD is the same as for the others KADs in Norway - to reduce the numbers of and spending for emergency referrals to specialized healthcare services by offering them at the municipal level (Oslo kommune. Helseetaten, 2013). The aim of the Oslo KAD is to offer emergency healthcare services as good as or even better than those offered by hospitals for

certain patient groups (Oslo kommune. Helseetaten, 2013). Emergency aid is understood as immediate or imminent need for examination, treatment or care within 24 hours from the first contact with the health services (Moxness, et al., 2012).

There have been two challenging factors from the date of establishment of the Oslo KAD. Firstly, the municipality of Oslo is facing a rapid population growth as well as increasing number of elderly patients, which has implications for the entire health sector and will also affect Oslo KAD in different ways. Therefore, it is essential to develop the KAD to make it function as intended. Secondly, there are 488 general practitioners in the municipality of Oslo, which is divided into 15 districts (Fastlegen.no, 2014). The priority goals are focused at present on establishing sustainable communication with GPs and developing IT systems which will increase both productivity and efficiency of the Oslo KAD (Baaske, Bringedal, Halvorsen, & Torgersen, 2013, pp. 53-54). Notwithstanding the IT facilities, such as a website with constantly updated number of available places and prepared guidelines for GPs (Oslo kommune, 2011), which have already been put in place, the Oslo KAD currently is facing a relatively low number of referrals from GPs in comparison to the average percentage from other municipalities in Norway (Sletvold, 2014; Snøfugl, 2013). However, the reasons of this phenomenon in Oslo remain unexplained.

## **1.2 Theory**

The goal of this thesis is to explore why the implementation of the KAD in Oslo has proceeded differently than planned. To implement this goal, the main objective to analyse the reasons for the low rates of patient referrals to the Oslo KAD by general practitioners has been set. For this purpose implementation theory approaches will be used.

There could be several reasons for the rates of referrals by GPs differing from intended rates. Insufficient information about the KAD could be one of them. However, there are clear indications that GPs in other areas of the country are referring patients to the local KADs at higher rates. If we assume that the information available to GPs in Oslo is neither inferior nor inadequate in comparison to the information available to GPs in other areas, what is the reason that Oslo stands out? What factors of the healthcare system in Oslo might explain this variation?

Could factors related to the organizational healthcare structure in Oslo explain this striking variation in the implementation of KAD?

It is possible that the knowledge about newly established facilities, experience using them, differences in organizing primary health care in Oslo and the rest of the country might have an impact too. The age of doctors, years of practice or contact with patients might have certain influence as well. Also, there might exist certain unpredictable reasons prior to commencement of the research. Due to that, the research will attempt at the analysis of all these possible factors which might have an effect.

The respective staff of the municipal emergency day care unit in Oslo are part of the research topic and were taken as a point of reference in comparing results with the other participants in the research project. The reasons of behaviour of general practitioners will be analysed taking as a basis qualitative data obtained from semi-structured interviews.

### **1.3 Data and methodology**

In this typical-case study GPs' behaviour towards patients' referrals to the Oslo KAD will be examined. The data for the research part of the thesis were collected through conducting semi-structured interviews with the staff members of the Oslo KAD and the emergency ward as well as several general practitioners. The interviewees represent the main data source in this research.

The data were recorded using a portable audio recorder. Following the transcription process, the data were processed using the content analysis method through six stages suggested by Creswell (2014, pp. 194-201): 1) Organizing and preparing data for the analysis; 2) Reading the data and reflection; 3) Coding the data; 4) Creating themes; 5) Interrelating themes; 6) Interpreting the meaning of themes.

### **1.4 Structure of the Thesis**

In the introductory part of this thesis a short description of referrals by GPs to the KAD in Oslo was given. The following chapter gives overview of the Norwegian healthcare structure and organization. More attention in this chapter will be given to the new incentives regarding the

establishment of municipal emergency day care units. Overview of the Oslo municipality is conducted to demonstrate the scale of concentration of healthcare facilities and numbers of GPs employed in the capital of Norway.

Chapter 3 presents discussion of the theoretical part which is based on Implementation Theory by Pressman and Wildavsky assumptions and van Meter and van Horn theoretical approach of top-down perspective. Different scientists' approaches were used because Pressman and Wildavsky assumptions lacks the clear model, while van Meter and van Horn's model lacks assumptions. Chapter 4 contains discussion of the data and methods used for the analyses of semi-structured interviews. The results of the research are presented in chapter 5. The thesis is finalized with the chapters including discussion and conclusion.

## 2 Background

To understand the role and importance of the KAD following the Coordination Reform, a brief discussion is required of the Norwegian healthcare structure and organization, and the organization of primary healthcare in Oslo. Furthermore, in this chapter I will discuss the legal framework of KADs in Norway and the commitments of the Oslo KAD.

### 2.1 Healthcare organization and structure in Norway

Healthcare in Norway is structured at three levels: the state, county and municipality. The state level, in particular, the Ministry of Health and Care Services, exercises supervisory functions for all hospitals in Norway, owns them and is responsible for secondary and tertiary care in country. Hospitals are organized under four regional health authorities: South-Eastern Norway RHA (*Helse Sør-Øst RHF*), Mid-Norway RHA (*Helse Mid-Norge RHF*), Western Norway (*Helse Vest RHF*), Northern Norway RHA (*Helse Nord RHF*), and are controlled through regional health boards (Ringard, Sagan, Saunes, & Lindahl, 2013).

The county level (Norway is divided into 19 counties), apart from enjoying an important role in resource allocation, has an additional responsibility for management of dental care. Up to 2002, the counties were also responsible for specialized health care services. The 2002 Reform switched hospitals to the state level (Ringard, Sagan, Saunes, & Lindahl, 2013, p. 19) and now they are under the state control exercised through five regional health boards. This change resulted in moving the entire healthcare system from being decentralized to semi-centralized (Hagen & Kaarbøe, 2004, p. 3).

At present their responsibilities include organizing public dental care in cooperation with the municipalities. The counties also have some responsibilities with regard to general public health. In principle, the county politicians have virtually no direct influence over the health care system (Johnsen, 2006, p. 20).

Municipalities (430 units) in Norway are responsible for primary health care and long-term care and rehabilitation services. Since 1984 they are responsible for financing and provision of primary health care services. These responsibilities are stated in the Municipal Health and Care Act (2011). According to them, municipalities are free to organize the provision, including



hiring GPs either as public employees or signing contracts with private physicians (Ringard, Sagan, Saunes, & Lindahl, 2013, p. 103). Municipalities by organizing primary health care services are responsible for prevention, diagnosis and treatment of illness, injuries and physical defects as well as provision of nursing care and care outside health care institutions. These responsibilities are implemented through general medical practice services, physiotherapy, nursing (both at home and at nursing homes), midwifery services and medical emergency call services (Johnsen, 2006, pp. 92-93).

In Oslo case, the capital of Norway is both municipality and county at the same time. Prior to 2002 the municipality of Oslo was responsible for emergency ward (in Norwegian – *legevakt*) in Oslo and the county of Oslo was responsible for hospitals. Emergency ward was part of the hospital system in Oslo (Interview with the respondent from the Emergency ward in Oslo, 2014). Over the years this organizational model has taken root in Oslo, the only one city in Norway where municipality and county are two parts of the same entity. Before 2002 the size of emergency ward had been on increase. Naturally, due to the abovementioned reasons GPs in the municipality made fewer and fewer home visits leaving this responsibility to the Oslo emergency ward. Following the 2002 Reform, the trends in primary healthcare services have not changed in Oslo and the situation remains the same (Interview with the respondent from the Emergency ward in Oslo, 2014).

Regarding the specialized healthcare services, one of the incentives of the Coordination Reform was to reduce bed occupancy in order to reduce waiting time for specialized health care services. In Norway the estimated rate of bed occupancy is 93% (while the EU average is 76%) and this is reflected in long waiting times for elective care. According to a 2010 OECD survey, 50% of respondents in Norway had to wait more than four weeks for a specialist consultation, and 21% of respondents had to wait four months or more for elective surgery; in both cases Norway scored as the third highest after Canada and Sweden (Ringard, Sagan, Saunes, & Lindahl, 2013, p. xix).

The growing economy was also one of the reasons of seeking for more efficient ways in both reducing the expenditures for health care and reducing waiting times at hospitals. In such way the complex Coordination Reform targeted mainly to reduce admission rates, length of stay, waiting time at hospitals, saving more money and increasing accessibility of specialized health care services. The aim to place greater responsibility at the municipal level was highly

emphasized. As a result it was decided to establish KADs in the municipalities where services would be highly accessible and of the same or even better quality than that offered by hospitals.

## 2.2 Organization of primary and secondary healthcare services in Oslo

Oslo is the capital and the largest city in Norway with 623,966 inhabitants as of 1 January 2013 (Statistisk Sentralbyrå, 2013). The municipality (*kommune*) of Oslo and county of Oslo (*fylke*) are two parts of the same entity. Oslo is divided into 15 districts: (1) *Gamle Oslo*, (2) *Grünerløkka*, (3) *Sagene*, (4) *St.Hanshaugen*, (5) *Frogner*, (6) *Ullern*, (7) *Vestre Aker*, (8) *Nordre Aker*, (9) *Bjerke*, (10) *Grorud*, (11) *Stovner*, (12) *Alna*, (13) *Østensjø*, (14) *Nordstrand*, (15) *Søndre Nordstrand*. Each of the districts has a corresponding hospital (see Figure 1). Lovisenberg Diakonale Hospital has its catchment area on Districts 1, 2 and 4. Diakonhjemmet Hospital on districts 5, 6 and 7, Oslo University Hospital (OUS) on districts 3, 8, 9, 13, 14 and 15. Finally, Akershus University Hospital (Ahus) is responsible for districts numbered 10, 11, 12 (Oslo universitetssykehus, 2011). Such a high concentration of health care facilities allows Oslo to treat patients at a premium quality level. However, due to constantly growing population in Oslo (i.e. the population growing by 48491 between 2009 and 2012) and ageing society, health care facilities are occupied at high level and this results in an increased waiting times at hospitals.

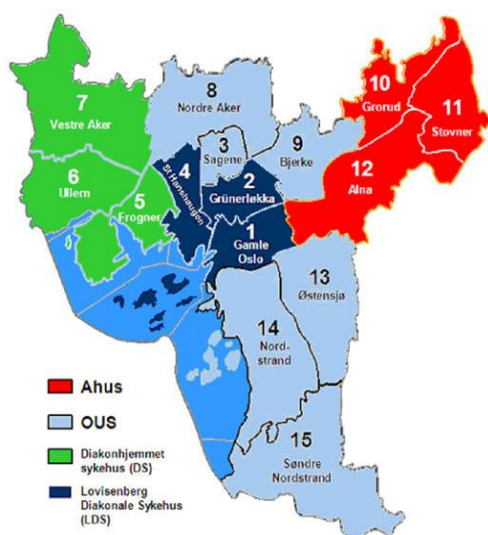


Figure 1 Map of Oslo's districts and corresponding hospitals (Source: <http://www.oslo-universitetssykehus.no/fagfolk/veiviseren/sider/kart-over-oslo.aspx>)

There were 488 GPs working at the municipality of Oslo in the year 2012. The number of GPs is growing gradually. Within the past decade, this number grew from 441 (in 2002) to 488 (in 2012) GPs. This number is growing annually and over the past decade numbers of GPs increased by 576 (from 3703 in 2002 to 4279 in 2012) (Statistics Norway, 2014). The increment of GPs in Norway is in a direct relation to ageing society and high immigration levels (from 35 to 78 thousand people annually since 2002) (Statistics Norway, 2014). However, there is one important fact which might account for low referrals rates to the Oslo KAD or any other KAD in Norway. It is the age of GPs (see Table 1). The number of GPs in the age category of ‘67+’ has increased noticeably over the last decade.

Table 1. Breakdown by age groups of general practitioners in Norway, 2002-2012. Source: Statistics Norway

	<b>2002</b>	<b>2006</b>	<b>2012</b>
<b>Age group</b>			
<b>0-29</b>	54	54	57
<b>30-39</b>	784	831	1110
<b>40-54</b>	2110	1875	1587
<b>55-66</b>	719	1031	1409
<b>67</b>	36	50	116

Despite the fact that the age category ‘30-39’ has also increased, there could be stagnating factor in the GPs’ choice of referral in the higher age groups.

## **2.3 The municipal emergency day care units (KADs) in Norway**

After the Government presented Report. No. 47 (2008-2009), the Coordination Reform has been detailed through the Public Health Law (2011), Health and Care Act (2011) and Report on National Healthcare Plan (2011). The legal aspect of the operation of KADs is described in the new Health and Care Act § 3-5, paragraph 3 (Helse- og omsorgstjenesteloven, 2011):

*The municipality shall provide an offer of inpatient health care services to patients and patients who need immediate help. Obligation applies only to the patients and users of these services whom municipality has the opportunity to examine, treat, or provide care for.*

The KAD is not regulated by the Basic Collective Agreement for municipal sector, neither by special agreements between municipal and the Doctors Association (*legeforeningen*), nor governed by the Framework Agreements (Veileder til utarbeidelse av avtalerom bemanning av kommunalt akutt døgnopphold (KAD), 2013). The main objective of the Coordination Reform (St. Meld. 47, 2008-2009) was to propose how coordination should effect further development of the healthcare sector. The reform proposed five main elements:

- A more defined role for the patient;
- New role for municipalities in the future;
- Financial incentives;
- Developing the specialist healthcare services to enable them to apply their specialized competence to a greater extent.
- Facilitating better-defined priorities. (St. Meld. 47, 2008-2009, pp. 14-16)

Regarding the new role of municipalities in the future, it is assumed that there will be an expected growth in demand in the overall healthcare and this issue should be solved at the municipal level. The background of this demand is related to the growth of elderly population in Norway as well as to the expected increase in the number of residents with chronic illnesses (i.e. COPD, diabetes, obesity) (Moxness, et al., 2012, p. 6).

Table 2. Population projection in Norway for 2020-2040 comparing with 2013 (Source: Statistics Norway)

	Age group	2013	2020	2030	2040
Male	<b>0-5 years</b>	193 379	213 889	227 975	223 768
	<b>6-15 years</b>	316 031	337 343	378 715	388 811
	<b>16-66 years</b>	1 730 775	1 855 750	1 958 142	2 015 566
	<b>67 years or older</b>	294 719	376 920	486 595	600 189

Female	<b>0-5 years</b>	183 146	202 927	216 248	212 258
	<b>6-15 years</b>	301 734	320 156	359 057	368 569
	<b>16-66 years</b>	1 652 655	1 758 969	1 858 920	1 925 365
	<b>67 years or older</b>	379 192	445 082	551 674	665 883

Municipalities are challenged to think about continuous care of patients and should ensure a holistic thinking with prevention, early interventions and diagnosis, treatment and follow-up on the best effective level of care. This includes, inter alia, a task shift from specialized health services to community health.

The goal of creating KADs is to make shift in admissions from hospital to municipal level when and where it is possible and thereby to reduce spending on expensive hospital services and waiting times for patients who are in greater need. *Helsedirektoratet* has estimated that the transfer rates of emergency admissions from hospitals to the municipalities may correspond to approx. 10% of admissions (Moxness, et al., 2012).

There are multiple variants of coordination and organization of the KADs. For example, 47 municipalities have established independent KADs for their citizens while 38 municipalities cooperated in establishing KADs (Snøfugl, 2013). Cooperation scope varies between 2 and 12 municipalities.

Municipalities report the information on patients' referrals to KADs. In its report *Helsedirektoratet* gave overview of 4021 admission cases to KADs from 115 municipalities in terms of location from where patients were referred (cf. Table No.3). The data covered 115 municipalities. 66% of referrals come from the emergency ward and 23% were referred by GP. The remaining 2% were referred from another doctor in the municipality, and 4% from a physician in the emergency department or specialist services (Snøfugl, 2013).

Table 3. Overview of referrers based on 4021 referral cases

	<b>Number of admissions</b>	<b>Percentage</b>
Emergency ward ( <i>legevakt</i> )	2647	66%
General practitioner ( <i>fastlege</i> )	915	23%

Other doctor in municipality ( <i>annen lege i kommunen</i> )	98	2%
Doctor in emergency unit or in specialized health care services ( <i>lege i akuttmottak eller spesialisthelsetjenesten</i> )	145	4%
Other ( <i>Annet</i> )	216	5%
<b>Total</b>	<b>4021</b>	<b>100%</b>

Admission times to the KADs also vary. However, there are no major peaks over 24 hours. 31% of patients are admitted at 8:00 and 15:30; 34% at 15:31-23:00; night time accounts for 10% of patients and, finally, weekends and bank holidays account for 25%<sup>2</sup> (Snøfugl, 2013).

One of the most important facts regarding the KADs already in operation is the age distribution of the admitted patients. According to the instruction, municipalities are requested to report on the age distribution of patients who have been hospitalized in KADs. The data from 116 municipalities cover 4,216 patients. 59% of patients are women and 41% men. Table No gives clear evidence that elderly patients dominate in the overall numbers of admissions (Snøfugl, 2013).

Table 4. Distribution of admitted patients by age group

Age group	Total number of patients	Percentage
Under 18 years	32	1 %
From 18 to 49 years	471	11 %
From 50 to 66 years	534	13 %
From 67 to 79 years	988	23 %
From 80 to 89 years	1 563	37 %
Over 90 years	628	15 %
Total	4 216	100 %

Patients admitted to the KADs mostly suffered from unspecified diagnosis or respiratory health disorders, for example, pneumonia. According to the data from *Helsedirektoratet* (covering 19

<sup>2</sup> Data from 47 KADs corresponding to 3020 admissions.

municipalities and 4423 patients) most of the patients are normally admitted for 1-3 days (these percentages vary by around 22%) (Snøfugl, 2013).

Table 5 Length of stay at KADs

Duration of admission	Total admissions	Percentage
Less than one day	682	15 %
One day	913	21 %
Two days	872	20 %
Three days	1037	23 %
Four days	359	8 %
Five days	184	4 %
More than five days	376	9 %
Total admissions	4423	100 %

Generally, the intention of creating KADs is to relieve 240 000 bed days in specialized healthcare service institutions - hospitals. This would be achieved by creating an additional number of 658 beds in the Norwegian KADs (Snøfugl, 2013).

After treatment patients are usually sent home (66%). However, 17% of patients are sent to municipal level institutions or nursing homes and 5% to specialized healthcare service institutions (Snøfugl, 2013).

## 2.4 Municipal emergency day care unit (KAD) in Oslo

As mentioned in Chapter 1.1, the establishment of the Oslo KAD proceeded in three stages. According to guidelines issued by the Directorate of Health, patients are admitted to the municipal emergency day care units with known and clarified conditions, diagnosis and function level. Prior to admission, a patient should be seen by a doctor (Veileder til utarbeidelse av avtalerom bemanning av kommunalt akutt døgnopphold (KAD), 2013).

The cause for this is straightforward. The municipality should make sure (after examination of a patient) that it would in a position to provide treatment. In addition, the municipality should

be guaranteed that the risk of admitting a patient is relatively small. Inpatient admission to a municipal emergency day care unit is unfeasible if there is a threat that it might worsen a patient's condition or if a patient requires lengthy treatment. It may also provide opportunity to examine patients with unknown conditions such as abdominal and chest pain, or any other conditions where hospitalization is not required.

The recommended maximum time before the patient is either discharged or transferred to another healthcare facility is set at 72 hours. It is related with the average length of stay and the aim to have available beds (Veileder til utarbeidelse av avtalerom bemanning av kommunalt akutt døgnopphold (KAD), 2013).

Provision of inpatient stays at the municipal emergency day care units is not applicable for patient groups including patients with acute and rapid deterioration of a known chronic disease, where an assessment of severity, comorbidity and functional impairment require immediate hospitalization. This also applies to functional worsening for elderly patients with chronic diseases, where finding causes may prove difficult and where there is a risk of rapid deterioration. Neither patients suffering from unresolved severity of trauma nor patients with a defined patient care, such as stroke or myocardial infarction, are suitable for admission to the municipal emergency day care unit, but rather to hospitals (see chapter 2.2.). As a rule, patients are admitted to the Oslo KAD with the following symptoms (Oslo kommune. Helseetaten, 2013):

- Reduced mobility (i.e.) stable fractures and contusions (soft tissue damage and swelling);
- Skin and wound problems;
- Urinary tract infections;
- Certain gastro diseases;
- Malfunctions with a known causes (clarified in specialist services);
- Respiratory and infection diseases (i.e. chronic obstructive pulmonary disease) and pneumonia requiring medical care but not mechanical ventilation therapy;
- Cognitive impairment;



- Chest pain (except cardiology);
- Pregnant women suffering strong morning sickness requiring anti-nausea treatment and rehydration.

As is obvious, a typical KAD patient is a patient for whom to stay at home would be risky, but who, on the other hand, is not in such a severe condition as to be admitted to hospital. It could be presumed that these patients are in a condition preventing their visit to GPs due to working hours of a GP or because they are poorly functioning to get to their GPs.

One of the intentions of the Oslo KAD is to admit significant numbers of patients who were referred by GPs. It is assumed that GPs know a patient's history better or even know them personally. This is regarded as the main goal of the KAD (Interview with the respondent from the Oslo KAD, 2014).

Table 6 Comparison of the patients' admission to KAD in Oslo and rest of Norway (Snøfugl, 2013; Sletvold, 2014)<sup>3</sup>

Oslo		Rest of Norway	
General practitioners	9%	23%	General practitioners
Emergency ward	43%	66%	Emergency ward
Home visiting doctors	14%	2%	Other doctor in municipality
Observation units	19%	4%	Doctor in emergency unit or in specialized health care services
Other	13%	5%	Other
Hospitals	2%		

Table 6 illustrates the comparison of admission rates to the Oslo KAD among different healthcare facilities and the admission in the rest of Norway (Snøfugl, 2013; Sletvold, 2014). The emergency ward in Oslo accounts for 43% share of the total admissions to Oslo KAD, while that of GPs stands at mere 9%. However, while the established KADs in Norway statistically receive patients from GPs at relatively high percentage, in Oslo this number is half as large (23% comparing with 9% in Oslo). For comparison in 115 municipalities with 4021

<sup>3</sup> Due to the different measuring some of the variables in Oslo do not correspond with the variables in "Rest of Norway"

admissions to KADs these numbers are 23% and 66% respectively. In that way it could be presumed that differences in healthcare facilities and organizational structure in the municipalities other than Oslo might be regarded as relevant factors.

### 3 Theory

The Implementation Theory developed in several waves in the 1970s and 1980s. There have been two dominant perspectives (Hupe, 2011) – the ‘top-down’ perspective known from Jeffrey L. Pressman and Aaron B. Wildavsky (*Implementation: How Great Expectations in Washington are Dashed in Oakland*, 1973) and the ‘bottom-up’ perspective of Lipsky (deLeon & deLeon, 2002)<sup>4</sup>. Today, these perspectives can be regarded as complementary. The ‘top-down’ perspective focuses on deviation of policy implementation from the intentions of policy-makers. This perspective usually captures variety of factors that may work for or against the implementation. The other, the ‘bottom-up’ perspective, analyses the situations of those who are charged with implementation of policies – the administrative officials who have to combine different policies and goals using available resources – and how they shape ‘policy in action’.

Regarding theoretical assumptions much could be said based on the Implementation Theory, which was formulated by Pressman and Wildavsky in the 1970s. Their first study on the implementation of policies became one of the major steps in studying public policy. Pressman and Wildavsky’s theories are mainly based on their study of Economic Development Agency (EDA) projects in Oakland-California funded by the U.S. Federal Government in 1965<sup>5</sup>.

Many scientists, including J. L. Pressman and A. B. Wildavsky, refer to Webster and Roget (Pressman & Wildavsky, 1973, p. xiii). According to Pressman and Wildavsky implementation means “to carry out, accomplish, fulfil, produce, complete” (Holzer & Schwetser, 2011, p. 22; Pressman & Wildavsky, 1973, p. xiii). This definition embodies the role of government to provide an efficient and equitable service to the people.

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<sup>4</sup> Researchers like Goggin indentified three generations of the Implementation Theory. The first generation is linked with Pressman and Wildavsky, the second generation and development of top-down and bottom-up approaches are represented by Van Meter and Van Horn, Mazmanian and Sabatier, Lipsky and Elmore. The last generation which tried to fill the gap between top-down and bottom-up approaches are represented by Goggin (Pülzl & Treib, 2007).

<sup>5</sup> Pressman and Wildavsky found out that everything appeared positive during the early years of the project. The policy was formulated, all participants had agreed on the overall goals, the specific public projects undertaken, and the employment plan was set in place. Financial allocations for these projects were also arranged. Implementation of the project was only a matter of technical details. However, the project started to fail when EDA began to experience delays during the implementation process. Deals that had been made with outside companies were being compromised by new cost estimates. Eventually, the project was declared a complete failure in the 1970s.

Pressman and Wildavsky's study was fundamental in the entire Implementation Theory (Holzer & Schwetser, 2011). They tracked the implementation of EDA through the years, and analyzed its various stages in detail. In addition, they systemized their insights and crystallized the so-called 'veto points' or assumptions which should be fulfilled (Kjellberg & Reitan, 1997).

Generally, Pressman and Wildavsky generated four assumptions regarding policy implementation. Firstly, the researchers assumed that (1) policy makers can't separate implementation from policy (Pressman & Wildavsky, 1973, pp. xvii, 143). Secondly, they were concerned about (2) elimination of delays in the chain of implementation, they were also concerned about the implementation process itself as they claimed that (3) inflexibility in preferences could lead to failure (Pressman & Wildavsky, 1973, pp. 118, 120-121). And last but not the least, they assumed that (4) people involved in the implementation process should be able for "knowing how" rather than to "knowing that" (Pressman & Wildavsky, 1983, p. 176).

Pressman and Wildavsky's study sometimes is criticized for the non-existence of accurate theoretical approaches (Kjellberg & Reitan, 1997). The reason is that they looked more into the entire policy implementation rather than through purely top-down approach (1973). Pressman and Wildavsky were deemed probably top-downers by later researchers of public policy. The linking with the top-down approach was due to the fact that researchers pushed the expectations in Washington (i.e. policy) to one side and watched how successful the outcomes (i.e. implementation) were in Oakland. By discovering the gap between the intentions (i.e. policy) and outcomes (i.e. implementation) Pressman and Wildavsky found out that the more links were observed in the vertical line between intentions and results, the smaller the chance of implementation there would be (Hupe, 2011).

Scientists like van Meter and van Horn used more accurate theoretical approach than Pressman and Wildavsky when analyzing policy implementation. Due to abovementioned weaknesses of Pressman and Wildavsky this approach will also be taken into account when analyzing results of the interviews. Their model consisted of the variables making exploration of the whole implementation process easier. These variables were: 1) inter-organizational communication and enforcement activities; 2) characteristics of the implementing agencies; 3) economic, social and political conditions. These variables created relations between implementation and policy (Van Meter & Van Horn, 1975). Actually, their model-based approach was one of the first

attempts to systemize the Pressman and Wildavsky’s assumptions. Scientists laid down the fundamentals for later research generations by creating structured, theory-based theoretical approach with clear variables.

The three abovementioned variables in the van Meter and van Horn’s model are summed up into derivative variable – “disposition of implementers” which is directly related with the performance (i.e. implementation) (cf. Figure 2 bellow). On the other hand, we already know the implementation and the policy (i.e. two opposite sides of the model) (Van Meter & Van Horn, 1975). Thereby, only the central part of the van Meter and van Horn’s model (three variables) need to be explored. Moreover, the implementation theory does not aim to explain “what it is?” but “why it is so?”

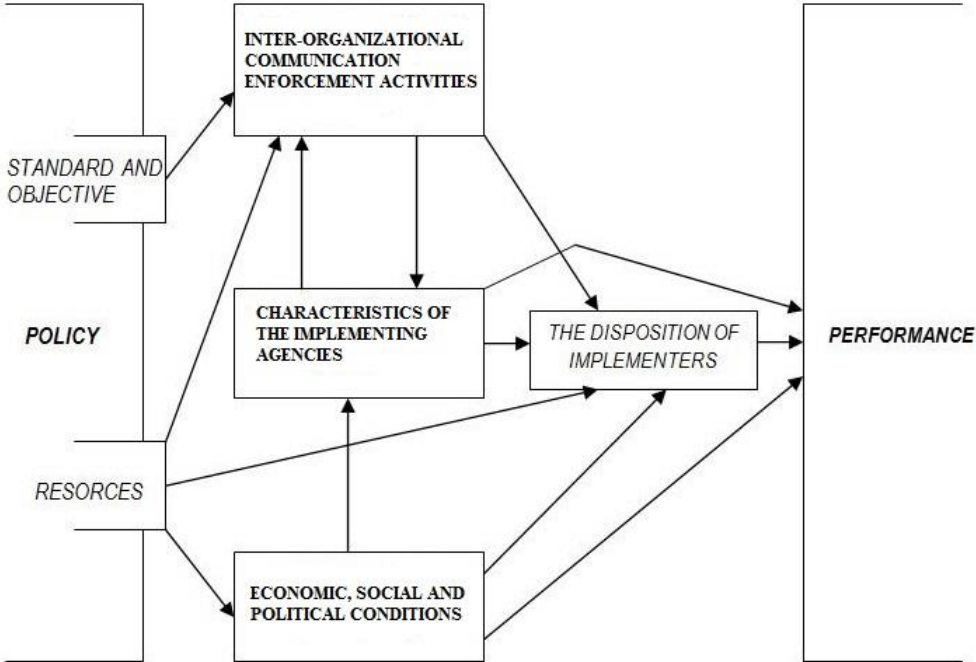


Figure 2. Model of the policy implementation by van Meter and Horn (Van Meter & Van Horn, 1975).

This master thesis aims to explain implementation of the Oslo KAD in terms of the factors which lead to low referral rates from the GPs. Therefore, the gap between the intended and implemented KAD will be explored, and the main factors of low referral rates from GPs hindering the implementation will be named. Pressman and Wildavsky’s assumptions of these factors will be tested in the discussion part. Factors, which do not fulfil any of the assumptions, will be deemed significant for challenging implementation of Oslo KAD and causing a GAP.

### **3.1 Application of the Implementation Theory to GPs referrals to the KAD in Oslo**

Firstly, the vertical chain of the implementation should be identified. The top of the chain is represented by government, the middle chain by the KADs in Norway, while the GPs are at the bottom of this chain (i.e. are one of the implementors of the policy).

General practitioners, constituting a part of the chain in the patients' referrals to the Oslo KAD, are presumed to act as intended (i.e. refer patients to the Oslo KAD) (Interview with the respondent from the Oslo KAD, 2014)). Despite the fact that the concept of the KAD works as intended in different smaller municipalities, Oslo might differ from Norway as a whole due to unforeseen factors. One of those factors might be that policy makers assumed that the KADs throughout Norway would operate in a uniform manner. However, in such municipalities as Oslo it might not happen and this could be regarded as failing to fulfil the first assumption by Pressman and Wildavsky (Pressman & Wildavsky, 1973, pp. xvii, 143) where they stated that implementation should not be separated from policy.

Another important assumption proposed by Pressman and Wildavsky (1973) was delays in the chain of implementation. However, delay in the narrow sense of the word is not a perfect definition to indicate the unwillingness or avoidance to refer patients. In general, there could be natural delays in the policy implementation caused by the organizational structure of healthcare facilities, information, experience and other factors. In addition, these delays on the part of GPs' could work as a challenge for better cooperation with the KAD, admitting patients and offering them the best possible or even a better quality of treatment than the one offered by hospitals.

The third assumption, which could be called 'inflexibility in preferences' (Pressman & Wildavsky, 1973, pp. 118, 120-121), is clearly related with GPs and their work. GPs might refer patients to large-sized health care institutions because they had done so for several years before or because it is easier for them. This assumption might fail to be fulfilled in Oslo as well due to the fact that the city has a high concentration of healthcare institutions (i.e. five hospitals in Oslo). It could be measured as the abovementioned 'level of acceptance'. In the analysis of semi-structured interviews this acceptance will be considered in terms of how acceptable vs. difficult it is for GPs to refer patients to KAD.

High level of changes and low level of acceptance result in a complicated implementation of the policy. However, small level of changes and high level of acceptance makes it vice versa. The ease of implementation from GPs' perspective will be discussed in Chapter 6.

The last assumption is "knowing how" rather than "knowing that" (Pressman & Wildavsky, 1983, p. 176). This means that GPs are inflexible because of insufficient information. Providing information to GPs about the KAD ("knowing that") is totally different from supplying all detailed information ("knowing how") about the KAD. There might be insufficient information regarding the newly established KAD in Oslo in terms of what kind of doctors and nurses are employed there, what equipment are available to the KAD or even what medical tests are available at KAD.

All these assumptions are related with the GPs as part of the chain in the implementation of policy or, in general, with the intentions of establishment of the KADs. At least one of these unfulfilled assumptions may produce unwanted outcomes and results. All the aforementioned assumptions will be tested to the fullest possible extent in the Discussion chapter where analysis of the results obtained from semi-structured interviews will be presented.

Regarding the van Meter and Van Horn's model, the variables should be discussed here as they will play an important role later on in the research. The first variable in their model is inter-organizational communication and enforcement activities. The most important determinant in this variable is the ability of the organizations to communicate fluently and thus implement the policy. Good logistics, sharing information among relevant stakeholders in the implementation process of the Oslo KAD leads to a better implementation. Enforcement activities in the implementation of the Oslo KAD are closely related to the communication.

The second variable "characteristics of the implementing agencies" in this research is related with the organizational structure of primary healthcare in the municipality of Oslo. This variable also interacts with the other two variables in van Meter and van Horn's model and play a significant role. Logically, the better the structure, the more fluent inter-organizational communication there is.

Economic, social and political conditions are also important in the implementation of the Oslo KAD. The better economic conditions, the more opportune prospects of a better implementation

of the policy (in our case the Oslo KAD). Moreover, the economic determinant of this variable could be measured as the opinion of the relevant stakeholders (GPs, staff members of the Oslo KAD) on the additional economic value of newly established institution. While social determinant does not play any role in the case of the Oslo KAD, political conditions should be discussed. Since the Coordination Reform encompasses all the municipalities in Norway, it is assumed that the political background is the same. However, what applies to other municipalities might not apply in the case of Oslo due to the interaction with the “characteristics of the implementing agencies” variable.

Factors when analyzing the low referral rates from GPs to KAD could be the lack of information not about the new incentives of under the Coordination Reform, but the services, facilities and capacities of newly established KADs as well as geographical factors (i.e. a highly dense concentration of healthcare facilities). In addition, there could be more factors that might be or not common for relevant stakeholders (GPs, Oslo KAD, Oslo emergency ward, hospital in Oslo). Prior to research assumed factors together with explored ones will be analysed through the implementation theory as well as the commonalities between them will be looked for. These commonalities will both help to reject or accept the hypothesis and strengthen the reliability of findings.



## 4 Data and methodology

Typical-case study was chosen for this thesis as it exemplifies what is considered to be a typical set of values and gives general understanding of a phenomenon (Box-Steffensmeier & Brady, 2008, p. 648). In addition, the case study provides opportunity for the extensively exploring and understanding rather than confirming and quantifying. Moreover, it is very useful when exploring an area where little is known and the holistic understanding of the situation is needed (Kumar, 2011, p. 127). In this thesis I intend to explore the phenomenon of low level GPs referrals to Oslo KAD.

As mentioned above, Oslo has nearly 500 GPs. Moreover, prior to the research it was assumed that due to the GPs' duties and tight schedules access to them would be very limited. Assumptions proved correct. Out of 452 e-mails sent, only 5 GPs showed their willingness to participate in the research and were interviewed. In addition, 2 GPs were added to the sample by making a telephone call and requesting them to participate.

Semi-structured interviews were chosen for several reasons. Primarily, the general framework of the topics was known prior to the interviews. Moreover, it was very important that respondents would express their attitudes and insights in their own terms and give rich, broad explanations. Therefore, neither structured nor unstructured interviews were suitable here.

Prior to the sampling, assumption was that the GPs' response rate might be very low. Therefore, the sampling for the research was selected by sending requests to all the GPs in Oslo via e-mail. All the respondents who were willing to participate in the research were interviewed. No assumptions regarding the GPs' age, gender, citizenship, district of the city were made when sampling.

Staff members in the Oslo KAD were interviewed before conducting the interviews with GPs. The sampling of respondents in the Oslo KAD was performed using the "Snowball" principle. This principle applies to the selection of respondents when the sample is difficult to access or its size is unknown (Rubin & Babbie, 2008, p. 174; Babbie, 2013, p. 201). This principle states that the number of respondents increases during the implementation of the research. The researcher first selects a few available respondents and later contacts other respondents, preceding guidelines and recommendations being at one's disposal. According to the

"Snowball" principle, respondents may even give contact information of other respondents who are familiar with the case (Rubin & Babbie, 2008, p. 174; Babbie, 2013, p. 201). This principle was applied conducting the part of the research in the Oslo KAD. Sampling and interviewing was terminated after 5 respondents had been interviewed and no new information received.

However, even though the "Snowball" principle has benefits like ease of accessing hardly accessible respondents due to the fact that previous ones suggest them, it has some limitations too. "Snowball" principle is not random sampling and a lot depends on the first interviewed respondent. The first interviewee's answers and contact suggestions for the other respondents could have an impact for all of the results (Neena, 2011).

The sample of the research included 5 interviewees from the Oslo KAD, 8 GPs in the municipality of Oslo, 1 respondent in the Oslo emergency ward, and one 1 respondent from one hospital in Oslo. The research design captures variation of opinions between GPs in Oslo and staff members at Oslo KAD.

The findings in qualitative study were checked for their validity and reliability in order to avoid any possible inaccuracy or miss trustworthiness (Creswell, 2014, p. 201). According to Golafshani (2003) definitions of reliability and validity in quantitative research reveal two strands (Golafshani, 2003). When testing reliability we are aiming to check whether the results in the research are replicable. Validity is related with the checking if measurements in the research are accurate and whether they are actually measuring what they are intended to measure (Golafshani, 2003). On the other hand, the concepts of reliability and validity are interpreted differently by qualitative researchers who strongly consider these concepts defined in quantitative terms as inadequate. In other words, these terms as defined in quantitative terms may not apply to the qualitative research paradigm (Gibbs, 2007).

There are several procedures which could be employed in order to check validity of the findings (Creswell, 2014, p. 202). The use of the following methods was selected for this purpose: 1) data triangulation method; 2) member checking; 3) rich and thick description; 4) bias clarification; 5) peer debriefing.

Triangulation method uses different data sources of information by examining evidence from the sources and using it to build a coherent justification for themes. If themes are established

based on covering several sources of data or perspectives from participants, then this process can be claimed or adding to the validity of the study (Creswell, Research design: Qualitative, Quantitative and Mixed Methods and Approaches, 2014).

Member checking is used to determine the accuracy of the qualitative findings through taking the final report or specific descriptions of themes back to participants and determining whether these participants feel that they are accurate (Creswell, Research design: Qualitative, Quantitative and Mixed Methods and Approaches, 2014).

Rich and thick descriptions are used to convey the findings. These descriptions may transport readers to the setting and give the discussion an element of shared experiences (Creswell, Research design: Qualitative, Quantitative and Mixed Methods and Approaches, 2014).

Bias clarification is another method for self-reflection which creates an open and honest narrative that will resonate well with readers (Creswell, Research design: Qualitative, Quantitative and Mixed Methods and Approaches, 2014).

Peer debriefing gives more accuracy to the findings. This process involved locating a person who reviews and asks questions about the qualitative study so that the account will resonate with people other than in the research (Creswell, Research design: Qualitative, Quantitative and Mixed Methods and Approaches, 2014).

Qualitative research reliability which indicates that the research is consistent across different researchers and different projects was proofed by selecting different methods suggested by Yin (2009) and Gibbs (2007). Firstly, the research and its procedures were documented in very detail (Yin R. , 2009). Secondly, transcripts were checked to make sure that they do not have obvious mistakes made during transcription (Gibbs, 2007). Thirdly, during the coding process it was assumed that there could be a drift in the definition of codes or a shift in the meaning of the codes. This was accomplished by constantly comparing data with the codes and by writing memos about the codes and their definitions (Gibbs, 2007).

## **4.1 Research Design**

Five semi-structured interviews were conducted at the Oslo KAD, eight with GPs in the municipality of Oslo, 1 interview was made with a respondent from the Oslo emergency ward and one interview with a respondent from hospital in Oslo.

Interviews were conducted in February-March 2014 and were recorded with the voice recorder Olympus VN-7600. All the interviews took place at the place suggested by the interviewee. In most cases this was their work place. A short introduction to the study was given to each participant. They were also informed that the interview would be recorded to the voice recorder. After their written consent form (see Appendix A) was signed, interviews would be started.

The interview guide (see Appendix B) was based on the statistics obtained from the Oslo KAD. Specifically, the main question to be answered was the possible reasons of low number of referrals from GPs to the Oslo KAD. However, there were other supplementary questions which followed up each of the statements in the interview guide. Supplementary questions were formulated according to respondents' answers, general attitude towards the case and other important factors. These questions were designed to obtain answers not only to the main research question, but also to find out possible presence of different reasons for general practitioners behaviour regarding the referrals.

In the interviews with respondents from the Oslo KAD supplementary questions were asked to investigate how the staff of the Oslo KAD see themselves in the context of Oslo municipality, the challenges faced by the newly established institution, their opinions and views on referrals by the GPs, and the ways for improvement of the situation.

Prior to the interviews with the GPs it was assumed that their knowledge, age, years of practice or contact with patients had some influence too. There could also be some unpredictable reasons prior to the research. Due to these reasons, it was aimed to find out all possible factors that could lead to low GPs' referral rates to the Oslo KAD during the interviews. In these interviews GPs were asked if they had ever referred patients to the Oslo KAD, what their opinions were; in what ways the Oslo KAD created additional value to the healthcare in Oslo; what kind of challenges related to referrals of patients to the Oslo KAD there were; how the situation could be improved and so forth. After all the interviews were conducted, the collected data were ready for transcription.

The analysis process encompassed six stages (see Figure 3) suggested by Creswell (2014, pp. 194-201): 1) Organizing and preparing data for the analysis; 2) Reading the data and reflection; 3) Coding the data; 4) Creating themes; 5) Interrelating themes; 6) Interpreting the meaning of themes.

In the first stage of the analysis process all organizational tasks, such as transcribing interviews, sorting the notes taken during the interviews and cataloguing them, were performed. In the second stage all the data were first read and general ideas from each interviewee were reflected by making notes in the transcription margins. The third stage covered coding of all the data. During this process the data were organized by bracketing chunks in the transcriptions and special category was provided for each of them. These categories were labelled with the term based on the actual language of the participant. In the fourth stage themes were created for the grouped labels of categories. The fifth stage covered the interrelation of themes. In this stage links between themes were sought for. After the linking themes were reduced into 9 categories and sorted into 3 clusters according to their significance. In the final stage, the results of this qualitative research were presented (cf. Chapter 5) and discussed by testing the assumptions of the Implementation Theory in Chapter 6.

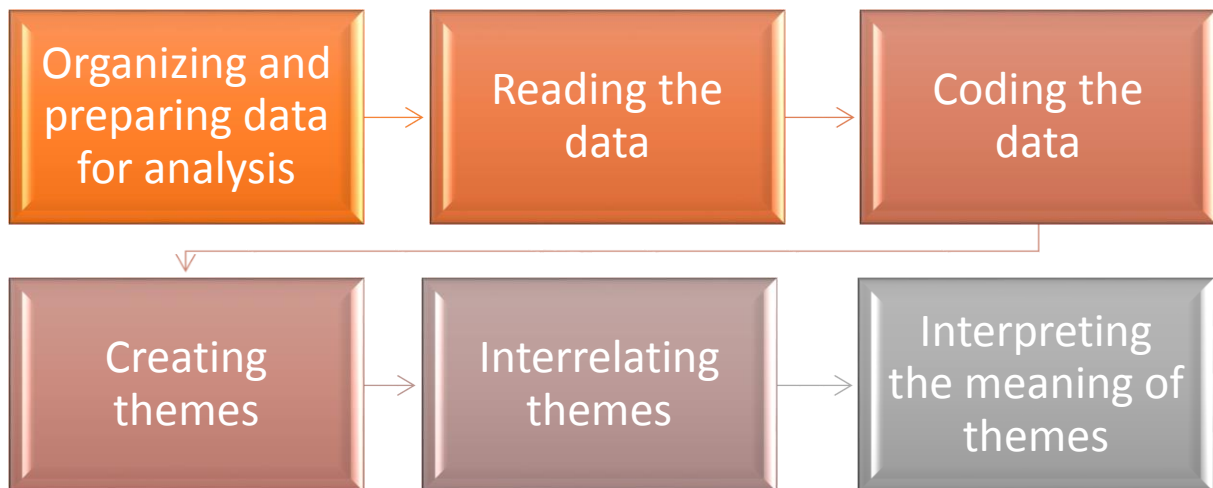


Figure 3 Six stages of data analysis according to Creswell (2014, pp. 194-201)

## 4.2 Validity and reliability

The findings of the research were checked for their validity and reliability in order to avoid possible inaccuracy. The external validity (also called generalizability) of the research aims to

check if the findings of the research could be applicable in other researches (Yin R. K., 2014). In case of this research external validity would aim to check if the findings on the implementation of the Oslo KAD could be applicable to other regions (municipalities or counties) in Norway, which have similar problems concerning patients' referrals. However, according to Yin (2014), critics of single case studies usually state that single cases offer a poor basis for generalizing. Those critics compare the situation to survey researches, but this analogy in case studies is incorrect (Yin R. K., 2014). While survey research relies on statistical generalization, case studies rely on analytic generalization. When conducting analytical generalization, a researcher generalizes a particular set of results to some broader theory (Yin R. K., 2014). On the other hand, by this research I aimed to analyze the implementation of the Oslo KAD only through the Implementation Theory. Therefore, not using a broader theory could be regarded as limitation of the thesis. The aim of this research as well as sample size is too narrow for the broader theoretical approaches.

Internal validity (also known as credibility) refers to how well the research is conducted, especially whether it avoids confounding (Creswell, *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, 2002). The lower is confounding in a research, the higher internal validity is. Several validity strategies were used for that purpose (Creswell, 2002, p. 202).

First of all, the triangulation method was used by introducing few different stakeholders from the Oslo healthcare facilities. Those included representative from the Oslo emergency ward and a doctor working at the one of the five hospitals in Oslo. The triangulation method helped to make sure that the data received from GPs and the staff from the Oslo KAD were not biased.

During the member checking the results of analysis (chapters 5 and 6) were sent to the respondents. Respondents were free to comment on the analysis results and outcomes. One week was given for this purpose. I paid much attention to their comments and all of them were taken into account.

Rich and thick descriptions helped to convey findings. These descriptions would let the readers determine if the situation described in the qualitative study applies to the reader's situation. Bias clarification was performed in the sub-chapter 6.3. All known and predictable biases were specified together with their minimization attempts.

Finally, peer debriefing gave more accuracy not only to the findings but also to the entire thesis. The supervisor of this thesis read it and gave valuable advices, remarks and comments. All of them were taken into account.

Reliability of the qualitative research, which indicates that the research is consistent across different researchers and different projects, was proofed by selecting different methods suggested by Yin (2009) and Gibbs (2007) referred to in Chapter 4 (Data and methodology). Firstly, the research and its procedures were documented in great detail (Yin R. , 2009). Secondly, transcripts were checked to verify that they have no obvious mistakes made during transcription (Gibbs, 2007). Thirdly, during the coding process it was assumed that there could be a drift in the definition of codes or a shift in the meaning of the codes. This was accomplished by constantly comparing data with the codes and by writing memos about the codes and their definitions (Gibbs, 2007).

One of confounding variables might be patients. They were not interviewed in this research due to the fact that I wanted to explore KAD-GPs-“Other stakeholders” interaction. However, patients were mentioned quite often by respondents and some factors might also be represented by them (such as economical, geographical, etc.). One of the important ethical consideration in qualitative interviews is the complete anonymity of the participants. The research was made by taking into account all requirements of Data Protection Official for Research at the Norwegian Social Science Data Services. All the information gained during the interviews was kept confidential. Only me and supervisor had access to the collected information. Audio recordings taken by an audio device were stored, kept and processed using password protected personal computer. As soon as the research was finished, all the audio recordings were deleted.

The respondents in the research were anonymized for not be directly identified later on. Every interview started with the signing consent form. Furthermore, there were no sensitive data registered in the research (i.e. patients’ names). All abovementioned ethical considerations were followed when collecting and analyzing the data.

# 5 Results

Participants in the research were asked questions based on the interview guide on the GPs' referrals to the Oslo KAD, as well as advantages and disadvantages of referrals, challenges (if any) from their point of view. The results of the research are presented below in three sub-chapters: 1) Staff members of the Oslo KAD; 2) General practitioners; 3) Other healthcare stakeholders in Oslo.

After the analysis of the interviews as defined in Chapter 4.1 the themes were arranged into categories. These categories were clustered into three main clusters (see Figure 4) as suggested by (Creswell, 2002)<sup>6</sup>: 1) Main categories 2) Leftovers; and 3) Unique categories. The first cluster covers “Differences of the facilities in Oslo”, “Time factor”, “Logistics”, “Informational factor”. The second cluster covers “Educational factor”, “Geographical factor”, “Management”; “Economical factor” and the third one – “GPs' habits”.

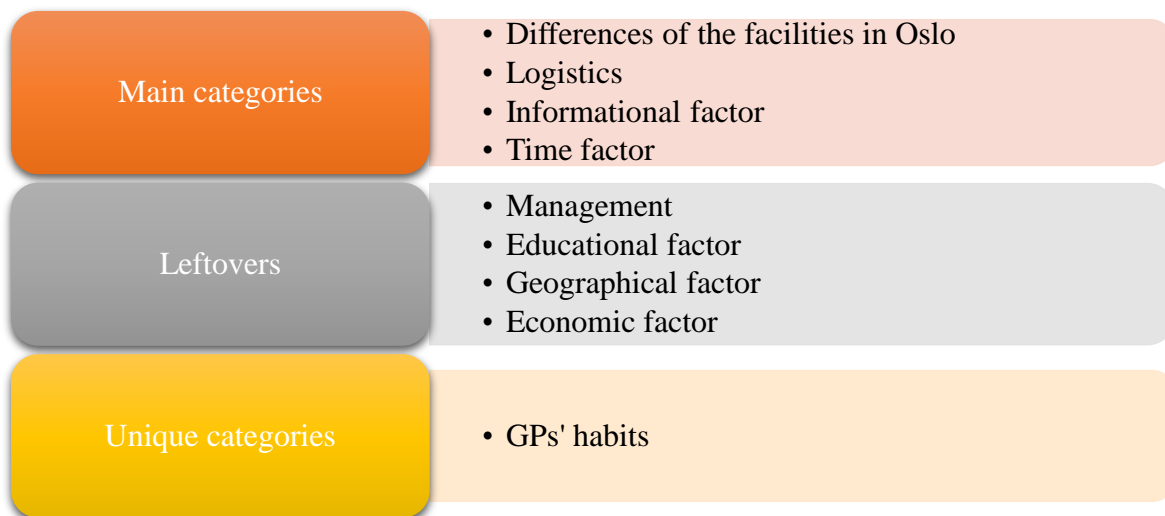


Figure 4 Distribution of the categories in three clusters

## 5.1 Staff members of Oslo KAD

### Differences of the facilities in Oslo

<sup>6</sup> Some groups of respondents didn't cover all categories in each cluster.



Respondents from the Oslo KAD showed unanimity regarding the health care facilities in Oslo. Most of them argued that these facilities were different from what could be found in other regions of Norway:

*But in Oslo you have 2 to 3 GPs just driving around the all Oslo, you have emergency acute orthopedic center, you have GPs acute emergency center 24 hours. So, therefore, you have a lot of channels which are admitting patients here.*

Majority of the respondents noticed that differences among facilities are the main reason for the challenges for the KAD implementation in Oslo. In addition, respondents even specified the main differences of the facilities. They claimed that the reason of the low GPs referrals to the Oslo KAD could be availability of the emergency ward in Oslo, which operates 24/7 and makes most home visits to patients. In smaller municipalities, the role of an emergency ward role is delegated to GPs, so they have a wider range of duties and much fewer options to choose between facilities.

*I think that in Oslo there are a lot of other areas which could refer patients to the KAD compared with other communities. Because in small peripheral areas there are only GPs. Even legevakt or emergency medicine also are part of GPs.*

## **Logistics**

Another important factor regarding the implementation of the Oslo KAD is logistics. This category covers communication, patient transfers and referrals. Respondents named IT issues as one of the challenge to a better implementation of the Oslo KAD.

*They have their own IT systems, they have own communication, a patient record systems. We are operating with totally different systems. So, coordination at that level is under process. They are working with new solutions, new IT programs*

According to the respondents, the Oslo KAD has limited communication capabilities with hospitals because each of them has its own electronic patient journal system. In addition, IT solutions used by GPs present another challenge by reason of many different electronic patient journals being in use access to which is unavailable for the Oslo KAD. Security of personal data was mentioned as a reason for this. However, patients' safety was claimed to be more important:

*Because I would say it is misunderstanding of patients secure of personality. It's misunderstood and it is not good. It is large risk for the patients' safety. The patients should have one journal and you can get it up wherever you are. It is not like in Norway. The patients could have 400 journals.*

Respondents also suggested that the single patients' journal could improve situation. On the other hand, they worried about protection of the personal data (even though the single patient journal does not exist yet in Norway).

Another issued of logistics faced by the Oslo KAD is their refusal of admission. Respondents argued that due to a poor examination by GPs, referrals are rejected sometimes. To improve the situation, interviewees mentioned a need for a better examination prior to admission at the Oslo KAD and a need for better communication with the GPs in the referral process.

*I think the main challenging this phase we are now is that the hospitals or the doctors are referring the patient and they are rejected. That is really the most challenging part of it.*

### **Informational factor**

Another bottleneck when the patient is fully referable to the Oslo KAD is informational factor. Respondents mentioned that only informational visits to GP offices helped them to increase the percentage of the patients' referrals:

*<...> with some papers sending out, but that was not good enough. We had to start visit round earlier. We didn't do that. That would maybe help us. <...> They haven't seen it because they have nurses or helesekretær working in front and sorting the post. They through them out what they don't think is useful for them. So, many haven't seen anything.*

Inadequate exchange of information and GPs who do not have yet information about the Oslo KAD were among the major factors making impact on low rates of referrals to the Oslo KAD.

### **Time factor**

Time, as a factor, was also one of the causes challenging implementation of the Oslo KAD. Many of the respondents mentioned that the newly established healthcare institution was in its early phase and not everything worked as planned from the start.

*<...> you know, it is a project which is in the early phase. We started in June, 7-8 months ago and we started with 2-3 patients. So, it is just from November until now we have proper working environment here.*

The time factor was also mentioned when the respondents were asked about possible reasons for low referral rates. They expressed opinions that it could be due to tight schedules of the GPs as they do not have enough time to call the KAD (then back to the hospital and then probably once again to the KAD).

*Then hearing that the patient has to go the KAD or the KAD says that the patient has to go to hospital. It is very time consuming for him.*

When asked what solutions to the present low referral rates there could be respondents also mentioned the time factor as a matter of natural development. They assumed that some time had to pass before the setup of healthcare facilities gave the intended results.

*So, I think with the passage of time it will be more visible and prominent.*

Last but not the least point was the admission criteria. According to respondents some time should pass before the criteria are adjusted and balance the interests and needs with other healthcare stakeholders in Oslo.

## **Educational factor**

From the cluster of leftovers the educational factor was mentioned as a challenge for the Oslo KAD, but it was not related with the GPs. When asked which main challenges the Oslo KAD encountered, few respondents mentioned education and experience.

*Of course every doctor and nurses they are not trained about every part of our work. So, we have a lot of things to improve.*

The reason for this may be a very short time which elapsed since opening of the Oslo KAD. Generally, there are GPs working there, but who had no practical experience with short hospitalized patients. While this is not a big challenge, nurses need more attention. According to the staff, nurses with extremely different background were admitted to work (after completion of studies, with several years of experience in one specialization, etc.) and require supervision to ensure services at the highest level.

## **Geographical factor**

Despite the assumptions in the theoretical part, the geographical factor was rarely mentioned by respondents. However, those few who mentioned the geographical factor stated that not only Oslo but other areas as well could have a relatively good access to hospitals.

*If you live in Oslo or in Fredrikstad or Hønefoss, it is not so far to the hospital. But in the northern Norway it is far to the hospital or the Western part. So that means for other places <...>. <...> in Oslo where you have five hospitals in very short distances between them, so I don't think it is economically beneficial to have KAD just beside the hospitals.*

Furthermore, some respondents argued that having the KAD in addition to a hospital might be unreasonable in economic terms due to a high concentration of healthcare facilities.

## **Management**

The issues of management from the viewpoint of Oslo KAD were rarely mentioned. As the main problem, the criterion of patient admission was put at the forefront. Respondents stated that the criterion could be broader because now the institution admits only a very narrow group of patients. Therefore, if the condition is not clear the admission could be rejected and it could be one of the reasons for low referral rates from the GPs.

Yet, respondents mentioned Oslo's healthcare problems, such as long waiting times at the hospitals, unavailable beds when patients really need them.

Generally, all of the respondents' opinion about the management at the Oslo KAD is good. Despite that, there were insights about other municipalities, which according to the respondents just started the implementation of KADs and this was quite a big challenge for them.

*I think they started very good. A lot of other communities they have KADs in the papers, but they are not able to define how they are going to operate with the KAD. Many of the GPs they are not willing to cooperate with the KAD in communities.*

## **Economic factor**

The economical factor was not among the most important ones. Even though one of the incentives of the reform was economical (to reduce the treatment cost), this was not so much

important for the respondents. Attitudes towards economic benefits for the whole healthcare system split.

*For the whole healthcare system it is possible to have an economical benefit, because the cost for one bed here supposed to be lower than at the hospital.*

Some of the respondents clearly stated that there could be economical benefits of establishing KAD, but others opined that the prices of services might be at the same level as in conventional hospitals. The most extreme opinion was that having KAD in Oslo was not economically beneficial.

*I don't think it is economically beneficial to have KAD just beside the hospitals*

### **GPs' habits**

There were some opinions that GPs' (especially those older) are so accustomed to refer patients to hospitals that they the even don't bother with new treatment opportunities.

*A lot of GPs continuing practice that they have had in many years.*

The reasons for this opinion could be the inflexibility caused by a GPs' age and previous 20-30 years experience of work in the primary healthcare sector. However, respondents emphasized that such inflexible GPs are very few.

## **5.2 General practitioners**

Out of the 9 groups, GPs covered only 5 groups in three clusters (Differences of the facilities in Oslo; Time factor; Logistics and Informational factor) during the interviews.

### **Differences among the facilities in Oslo and other municipalities**

During the interviews GPs primarily focused on comparing the differences between facilities in Oslo and other municipalities in Norway. Most GPs mentioned the emergency ward in Oslo as being the most important structural difference comparing with other municipalities. According to them, in smaller municipalities the duties and responsibilities of an emergency ward are delegated to GPs and, therefore, they play a significant role in referrals of acute patients to KADs.

*That's because in Oslo the legevakt takes quite a big proportion of acutely ill people and we see less of them. Whereas if you work outside Oslo as a GP you see all the patients including acutely ill because they don't have the legevakt.*

The second feature of differences stated was home visiting of patients (in Norwegian: *sykebesøk*). Respondents argued that due to a different organizational structure in Oslo home visits are made by doctors from the Emergency ward, while in other municipalities, without emergency wards, it is done by GPs. Also GPs stated that they had very tight schedules and there was not enough time left for home visits. Finally, they also agreed that there was a lack of appointment slots assigned for acute patients who are physically able to arrive at their office. These appointment slots are filled up from early in the day by typical non-KAD patients.

*I think that generally they show lack of appointments to GPs in the acute setting. So all the GPs are obliged to have some appointments for the emergency patients, but they are usually filled early in the morning so if you have 3-4 appointments, which are free then people call early in the morning and they want to get the appointments that day. Therefore, if they call later than that there is difficult for them giving the appointment.*

GPs argued that a typical KAD patient is one that is unable to come to the GPs' office (old, poorly functioning, confined to bed, etc.). According to GPs, such patients in Oslo are visited at home by the doctors from the emergency ward and not by GPs.

*And many of the KAD patients they are so weak that they cannot come to the doctor's office. So, they often call the legevakt to get a home visit. Because legevakt has this home visiting service.*

### **Informational factor**

The informational factor was a second significant factor after the 'Differences in facilities'. In each conducted interview, GPs mentioned the lack of information about the services offered by the Oslo KAD. Most interviewees have been already visited by a representative from the Oslo KAD. Consequently, they possessed some knowledge about the conditions applicable for patient admission and services provided by Oslo KAD. However, many of them emphasized the technical aspect.

*<...> KAD has much value, but I feel that we lack a bit more information about the activity of KAD. How the patients are treated there, how advanced are the blood tests? What kind of treatment they can give what kind of observation they can do?*

These questions from the representatives show that they still lack information about the Oslo KAD, it also brings up a question of the effectiveness of the representatives' visits at GPs' offices. Furthermore, there were opinions regarding the need for more intense sharing of information. Respondents argued that periodic visits could help to improve the situation.

*I think they need to send the same information again and again. Because, you know, the GPs are hard learning. So, they do not learn so fast.*

## **Logistics**

Logistics has a significant role to the GPs plays in referring patients to the Oslo KAD. Generally, the GPs agreed on the need to improve communicational tools (and establish new ones) with the Oslo KAD in order to refer patients in an easier and faster way. Among the tools mentioned by the respondents are databases, the single electronic patient journal and electronic communication instead of sending paper documents. On the other hand, there were contrary opinions voiced regarding IT technologies.

*It is much better to have a telephone contact and speak doctor-to-doctor communication which is very accurate and educational for both parts.*

This 'as right as it gets' attitude, in addition to unwillingness to cooperate and develop, shows the lack of integration in the municipal healthcare community.

Most of GPs showed unanimity of opinion that the Oslo KAD was a valuable stakeholder among healthcare facilities in Oslo. It creates a place for patients who are not suitable for admission to hospital, but who may be exposed to risk if staying stay at home. However, some GPs saw disadvantages in patients' referrals in terms of logistics. In particular, admission criteria were mentioned most often.

*The disadvantages is that...it seems that lot of conditions need to be very cleared out before they can go to KAD. So, the patients are then excluded <...> But if you are so sure and then...probably the patient could stay at home*

Short working hours of GPs was mentioned as one of the reason why the emergency ward in Oslo refers more patients than GPs do.

*And maybe because in Oslo people can't come to the doctor during the day. They go to legevakta. <...> because these patients cannot come to the GP they automatically call the*

*legevakt and get a home visit and then go on this way. So, if the GP could have more home visits so then the rate could have been higher.*

## **Time factor**

Like the staff from the Oslo KAD, GPs also mentioned the time as one of the factors which had impact on the referral rates from them. They said that the time elapsed since the KAD in Oslo was opened (in mid 2013) was short. Moreover, the short time that had elapsed was mentioned as a reason for the lack of experience.

*Maybe it is <...> not worked in our minds yet.*

However, the time factor in this case could be related to the informational factor as well. The GPs also argued that they had not referred any patients due to the novelty of the KAD.

*I have no personal experience because it is relatively new.*

## **Management**

There were also some opinions regarding the ways the management of the healthcare in Oslo could be improved.

*They have to expand bit more, do something more a bit. Do more than the patients who are diagnosed and who only need this basic treatment, you know. They could also do some diagnosis at least*

Furthermore, some respondents claimed that the better exposure of the Oslo KAD could improve the present situation.

*Yeah I think it is about marketing. How they expose themselves.*

Some criticism was expressed about the staff on duty at the KAD. There were opinions that the staff at the Oslo KAD had to be increased due to a large scope of duties assigned to the current employees.

*Once I called the KAD just to talk to the doctor they had one doctor on duty and he was responsible for the patients admitted there and he had to have patients' visits and to attend the telephone calls.*



## 5.3 Other healthcare stakeholders in Oslo

Interviews with the respondents from other institutions were chosen for several reasons. Firstly, it enhances validity of the research as answers from interviewees were analyzed as a third part of data sources (triangulation method). Secondly, most of the GPs and respondents in the KAD group mentioned the Emergency ward in Oslo as a stakeholder in patients' referrals. Therefore, these assumptions needed to be tested. Respondents from the Emergency ward in Oslo (in Norwegian: *Oslo legevakt*) and one of the hospitals in Oslo covered 6 categories in the all the three clusters.

### Hospital in Oslo

#### Differences of the facilities in Oslo

The respondent from one of the 5 hospitals in Oslo argued that one of the main reasons why admission from GPs in Oslo and the other municipalities in Norway differs is the different facilities of the primary healthcare.

*<...> and I am kind of sure of, they have like KAD for several years already. They have like nursing homes with like a lot of nurses working, they have specially trained staff. They are used to if they get sick, they are far away from the hospital. So, treatment happens in these medical center or at nursing homes where they have some special equipment and they have specially trained nurses and they can access doctors.*

Moreover, the interviewee enlarged upon these differences. A respondent from the hospital maintained that it was not only GPs who had broader responsibilities but also all small facilities in other municipalities were charged with multiple responsibilities and had had a very similar structure to that of the KADs being established for many years now.

#### GPs' habits

However, the interviewee argued that for some GPs it could be hard to change the habits because they assumed that admitting patients to hospitals was safer.

*I think it is a more about changing a habit. And the habits is there. They always done it and they continuing doing it. And we see a lot of the patients coming here are patients that could be sent to KAD. Sometimes doctors are of course discussing this and some of them are*

*sent to KAD and some of them here. They want them to be admitted here you know. And I do understand that. If you are the GP, the whole medical history is with this hospital.*

In addition, respondent mentioned that medical history was available at the hospital where a patient had been referred before. This supports the GPs and staff idea of the KAD regarding the need of the single patient journal. In that way it would be easier to overcome the habit of attachment to a particular hospital and it would probably enhance the probability of referrals to KAD made by GPs.

### **Informational factor**

Informational factors were also mentioned among the challenges in changing the current situation. However, no definite opinion on the manner of effective dissemination of information in popular and acceptable form was given.

*But is not easy you know. Because GPs receiving patients all day through. For them to take time-off and go and see KAD, go for information meetings, etc., etc. it is actually like reducing their own salary. How interesting is that? SO I am not sure how actually you can solve the problem maybe written information, e-mails, contact over the phone for those who are...*

Much was said about the present lack of information among the GPs. The respondent stated that some GPs use the KAD quite a lot, while the others do not. Furthermore, the lack of information available to GPs creates inflexibility in preferences. These statements support the findings obtained from GPs and staff members of the Oslo KAD. There is a need for strong informational campaigns on the part of the KAD. Moreover, these statements were repeated several times when answering to different questions. This also shows that the informational issues play a significant role in the patients' referrals to the Oslo KAD.

### **Time factor**

The time factor was mentioned a few times and might be regarded as a significant factor. It was mentioned in relation to the fact that Oslo had a large number of GPs and it could take time before the KAD gained a firm footing in the framework of primary healthcare.

*I mean a special for the GPs. It takes time to make changes and especially...it is huge group – the GPs.*

## **Logistics**

The logistics factor was directly related to the admission flexibility by the KAD. The interviewee argued that to get in touch with the GPs it required much effort to be put in the flexibility of admission. Sometimes, the doctors at the Oslo KAD refuse to admit one or another patient even though the admission criteria are applicable to do so.

*Especially at the beginning and this is still the beginning I think it is super important to be flexible and to actually accept the patients that the GPs are sending, because if they are contacted the KAD and that they feel that the patients are not being admitted for some reason I don't think that they going to do it again.*

According to him, the newly established institution could be more flexible if they wished to prevent refusal to use the KAD just because of the previous experience.

## **Oslo emergency ward**

### **Differences of the facilities in Oslo**

While GPs argued that a typical KAD patient is referred by the Oslo emergency ward, the respondent from the latter institution had its views on this case as well. The respondent from the emergency ward in Oslo argued that there was a general trend of decrease in the rates of GPs' home visits. Therefore, total numbers of GPs' referrals to the Oslo KAD could be different comparing with other municipalities. However, more attention was paid for healthcare organization in Oslo. As for the main factor of low GPs referral rates, the respondents expressed opinion that it could have been influenced by natural emergency ward development<sup>7</sup>. Over the years it has significantly expanded. The interviewee said that the emergency ward in Oslo accounts for 25% of home visits to patients in Norway. However, the interviewee thought that the concept of KAD is perfect for small places because more patients are admitted there to KADs from GPs due to the organization of primary healthcare. Oslo in this case demonstrates an opposite trend.

*The model is very well suited for small places, far away from the hospitals because there the GP and the KAD function would be very easily integrated and tied together. So, you*

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<sup>7</sup> Emergency ward was established in 1900 and over the years gained a foothold in Oslo healthcare organization

get this effect. The problem in Oslo is that the KAD is going to be fairly large institution and is going to have very large amount of GPs and home services to cooperate with.

## **Logistics**

There were plenty of logistical factors mentioned by the respondent from the emergency ward in Oslo. Generally, the patients' pathways were given prominence during the interview. The respondent expressed a clear opinion that patients should be referred by their GPs and not by the emergency ward. Furthermore, an additional stakeholder was mentioned – nursing homes and their services. According to the interviewee these three stakeholders (GPs, the Oslo KAD and nursing homes) should try to establish better cooperation and then the emergency ward naturally will drop out from the present pathway.

*I believe that you quite right when you say that GPs, the KAD and the home services... If we can manage to have some kind of cooperation between these three, where the legevakt and the hospital does not play the central role that would be very good solution for the very lot of patients. Absolutely. I think...*

Another issue represents IT solutions and, in particular, access to patients' journals. However, it was noted as a challenging idea due to large numbers of GPs in Oslo.

*We would like to have access to for example the GPs' books to see when they are available, when they are in their offices. That could perhaps be solved by IT solutions. But that's a fairly large project with 500 GPs in our area.*

Finally, as a solution how to increase the GPs' referral rates it was suggested that home visiting services from the emergency ward should be cut down. However, at the same time the respondent doubted if it would be achievable due to emergency calls, unavailable GPs, and so on.

*We could try to cut down sykebesøk from the legevakt, but there are all emergency visits. So, it's not easy for us to do that. We would have to call the GP and make them go. And I am afraid that is a fairly difficult thing to do.*

## **Informational factor**

There was a strong evidence of information shortage among the GPs. The respondent had misgivings about GPs in Oslo getting confused, there being so many possibilities to refer

patients, and even be unable to make an effective decision where a patient should be referred to.

*I would not be surprised if many GPs would say that this is so complicated I really need to decide what ward is the best to stay either the hospital or at the legevakten for treatment*

It was clearly stated that GPs might have inadequate information about the Oslo KAD and therefore choose the easiest way for them – referrals to hospitals.

*We have a lack of information from the GP. We can send the patient to the KAD. We know the KAD. So, we send them there. But if the general practitioner goes there to the patient he would probably put the patient to the hospital, because he doesn't have the information about the KAD*

### **Time factor**

The time factor was mentioned just as a matter of natural development. Conversely to the other groups of respondents this factor did not get a single mention.

### **Management**

From the managerial point of view there were opinions that the KAD in Oslo will face similar issues which other healthcare stakeholders encounter in Oslo.

*<...> if we don't succeed the KAD will have the same kind of coordination problems with the rest of the first line services that the hospitals have. So it is very challenging...it is a big challenge to make the KAD work with such a centralized organization that we have in Oslo.*

Last but not the least in terms of importance was the reference to politicians regarding the management problems of the Oslo KAD and the entire healthcare system in Oslo. According to the interviewee, lack of political will to change the current situation and the thinking that everything was going just fine was damaging both for the system and for the patients. Politicians at the municipal level are those who implement the state policies and they are directly responsible for the results.

*I do not think that the politicians feel they have to do something to fix this. They feel that this works OK.*

# 6 Discussion

## 6.1 Study objective

In this master thesis my aim was to examine whether implementation of the KAD in Oslo has proceeded as intended. The key focus in the research was given to referrals to the Oslo KAD on the part of GPs. Any unfulfilled assumption by Pressman and Wildavsky should be regarded as a significant factor bringing forth the gap between the intentions and actual implementation of the Oslo KAD.

To accomplish the abovementioned aim, semi-structured interviews and their content analysis were conducted. Firstly, the interviews from the Oslo KAD were analyzed to understand the main goals, challenges and expectations from the viewpoint of this institution. Based on the obtained data, the GPs interviews were conducted later on. The main factors explaining the differences between low rate of referrals from GPs to the KAD in Oslo and the higher countrywide average were searched for. Finally, to enhance reliability, other healthcare stakeholders were interviewed about cooperation between GPs and the Oslo KAD, challenges and perspectives. After the content analysis of all the interviews was finished, the results explaining the factors of low referral rates were reduced into 3 clusters covering 9 categories. In the following sub-chapter the main findings will be discussed from the perspective of the theory of Implementation.

## 6.2 Main findings

The hypothesis of this master thesis could not be rejected since there are common factors indicated by relevant stakeholders in Oslo which challenge the implementation process of the Oslo KAD. The conducted research has revealed that there are several factors which lead to unfulfilled assumptions by Pressman and Wildavsky, weaken the variables of the van Meter and van Horn and thus create a gap in the policy implementation.

The gap between the Oslo KAD as intended and implemented is represented by the numbers of patient referrals. It is caused by a different organizational structure of primary healthcare in

Oslo, which is the most important factor among those investigated. Other significant factors proved to be informational factor, logistics and time factor.

Firstly, all the respondent groups argued that the organizational structure of healthcare system in Oslo differs from other municipalities in Norway. The Oslo emergency ward was mentioned as the main factor of these differences. It was established in 1900 and gained a foothold within the healthcare system in Oslo. Patients prefer to go directly to the Oslo emergency ward rather than to GPs offices. Therefore, more patients are referred from the emergency ward as opposed to GPs. The second reason is that during and after GPs' office hours home visits are usually made by the emergency ward. On these home visits doctors from the emergency ward meet typical KAD patients who are in a condition (in most cases elderly and hardly functioning) that prevents them from seeing their own GP. Moreover, there is a recent tendency where such patients themselves arrive at the emergency ward. The situation is totally different in smaller municipalities where emergency ward duties and responsibilities are in the hands of GPs. Therefore, GPs in smaller municipalities are far more integrated and linked to primary healthcare services, including KADs, without exception.

This as yet unsolved problem of the differences does not fulfil the assumption of policy being not separated from implementation by Pressman and Wildavsky (1973, pp. xvii, 143) and the Oslo case works as a clear example because a single pattern does not operate evenly throughout all municipalities in the country.

Information appeared to be the second most important factor of low referral rates to the Oslo KAD. GPs suffer from shortage of information about the Oslo KAD. In addition, the assumptions made prior to the research that GPs had inadequate or less information about the KAD proved to be true. Furthermore, after a careful analysis it emerged that informational campaign has been already launched and a few dedicated staff members seek to present the Oslo KAD face-to-face to nearly 500 GPs. However, even the informed GPs lack information about doctors, nurses, tests and equipment available at the KAD. In every interview GPs mentioned lack of information.

The abovementioned findings do not fulfil the assumption of "knowing how" but rather "knowing that" by Pressman and Wildavsky (1983, p. 176) and create an obvious obstacle for implementation of the KAD in Norway. From the perspective of GPs there is a need for more

frequently held information campaigns. Prior to the face-to-face presentations, the Oslo KAD had sent letters and e-mails and advertised their webpage. This failed to reach the focus group (probably due to medical secretaries who sort the ingoing correspondence and regards the information from the KAD as 'not important'). Therefore, the only solution might be live promotion of KAD services.

One of the issues regarding the Oslo KAD implementation could be related with the logistics. The staff from the Oslo face issues related to information on patients referred from GPs due to inaccessibility of patient journals. When admitting a patient, the Oslo KAD possesses inadequate information about medical history of a patient. The idea of creating a single patient journal for all the GPs in Norway was formulated by the two main respondent groups. However, because of lack of political will on the part of policy makers and deficiency of both technical and financial resources to be allocated for implementation, this idea seems to be postponed for the future.

However, at least from the perspective of the KAD, a single patient journal might improve the situation. If only authorized health personnel would be given access to vital health records (gain adequate information) of a patient, it would enhance speed, efficiency and effectiveness of the treatment. In addition, this tool could be used for statistical, quality measuring and other purposes. However, all the respondent groups had misgivings about solutions related to security of personal data (even though a single patient journal is not yet introduced).

Communicational tools (i.e. IT tools) between GPs and Oslo KAD were also mentioned as requiring improvement. At present, the largest share of communication is conducted via telephone calls which are deemed inefficient by GPs. Phone inquiries whether a patient could be admitted or not were regarded as time consuming for both parts, especially for GPs. Therefore, GPs opt to refer patients to hospital more often thereby saving time.

The narrow admission criteria used by the Oslo KAD and GP's working hours present a logistical obstacle for GPs. It creates uncertainty for doctors and, naturally, patient flows are forwarded to the Oslo emergency ward.



These abovementioned logistical challenges to the establishment and ensuring a smooth communication and cooperation between GPs and Oslo KAD do not fulfil “the elimination of delays” assumption by Pressman and Wildavsky (1973) and postpone the implementation.

At the first glance, time might be viewed as an insignificant factor if we assume that all municipalities have had or even have equal opportunities to establish the KADs. However, all the respondents from both respondent groups claimed that the whole concept of the KAD is very new not only in Oslo, but in the whole of Norway. Therefore, it might take time not only to communicate information to GPs, but also for them to understand the concept. Furthermore, the time factor was also used to express the natural development of the Oslo KAD. Some of the respondents argued that some time should pass before the KAD finds its place in the organizational structure of primary healthcare in Oslo.

Two others clusters, “Leftovers” and “Unique categories”, were mostly covered by the staff from the KAD and not by GPs or other respondent groups. This is a clear proof that economical, educational, and geographical factors do not have a significant role in the implementation of the Oslo KAD in terms of patient referrals. However, the management factor proved to be linked with policy makers (and also with the assumption of not separating policy from implementation). Assumption could be made that the Oslo KAD will not change the organizational structure of healthcare in Oslo on its own. Political decisions at higher levels should be made in order to receive more patients referred from GPs. Finally, the responsibility for management of the healthcare system in Oslo is under control of the municipality and the county. Those two administrative units should commit to implement the Oslo KAD in the best possible way.

The last assumption by Pressman and Wildavsky, namely ‘inflexibility in preferences’ (which could be called “level of acceptance”), was fulfilled. Assumptions made prior to the research did not prove true as the factors, which could cause inflexibility, didn’t play a significant role in the research. GPs gave a positive evaluation of the Oslo KAD; they were keen to refer and did not consider the establishment of the Oslo KAD as neither a ‘big change’ nor ‘big challenge’. According to them, establishment of the KAD could improve treatment quality, cut down waiting times at hospitals and save finances.

Neither the variables in Van Meter and van Horn's theoretical approach of implementation theory allowed rejection of the hypothesis. The first variable played a significant role in the implementation of the Oslo KAD case. The respondents, GPs and the staff from the Oslo KAD, agreed that inter-organizational communication could facilitate implementation of the Oslo KAD. However, the respondents' answers showed that the situation today is contrary. Currently, there is a great deal of misunderstanding regarding logistics and logistics and clinical pathways. Furthermore, sharing of information between the relevant (and the most important to the KAD) stakeholders, which should have been completed earlier, is still in progress. Therefore, the informational and logistics factors challenge the inter-organizational communication and slacken the implementation.

The second variable, "characteristics of the implementing agencies", could be related to the organizational structure of healthcare in Oslo. The vast majority of respondents stated that organizational structure of primary healthcare in Oslo was different due to availability of the Oslo emergency ward (in Norwegian: *Oslo legevakt*). However, it was found out that the high concentration of healthcare facilities in Oslo, the age of GPs, and years of practice are not the most important factors when choosing destination of patient referral. While the emergency ward in Oslo conducts visits to homes of typical KAD patients, GPs are being left with few options to refer patients to the KAD. In conclusion to this variable, it could be said that organizational structure of primary healthcare services and organization as such are the most important factors in this variable and in the case of implementation of the Oslo KAD.

Economic, social and political conditions variable played the least role in the results. Just a few respondents stated that there might be an economical benefit gained from establishment of such an institution. Some GPs even expressed doubts or maintained that there was no economical benefit to be gained from establishing the KAD. While this variable could be treated as not crucial in the whole process of implementation of the Oslo KAD, we should look deeper for the reasons. As it was mentioned in Chapter 2, the intention of the KAD (apart from the intention to offer the same quality or even better healthcare services) is mainly to reduce waiting times and treatment costs. Thus, it is purely an economical intention. However, the absence of economical insights regarding establishment of the KAD shows that comprehension of the KAD concept and possible benefits has not been fully acquired yet.

The research results have shown that neither the high density of healthcare facilities in Oslo nor the geographical factors, age, years of practice play any significant role in the implementation of the Oslo KAD. Other factors as discussed in Chapter 2.2, when analyzing the low referral rates from GPs to KAD, could be inadequate information not of the new incentives of the Coordination Reform, but of the services, facilities and capacities of the newly established KADs as well as geographical factors (i.e. highly concentrated healthcare facilities).

Theoretical assumptions of Pressman and Wildavsky as well as van Meter and van Horn's variables in their model approach showed that the most important factors explaining the low referral rates from GPs to the KAD in Oslo are organizational structure of primary healthcare services, information, logistic and, generally, the novelty of the KAD as a concept.

### **6.3 Limitations of the study**

This study has specific limitations related to participants in the research, sampling, the data collection method, interviews, coding process of the retrieved data, analysis, results, and the theory.

Despite the fact that the data were collected with the purpose to minimize all possible biases there could be some limitations in the data retrieved by conducting semi-structured interviews.

Firstly, interviews give indirect information from the viewpoint of respondents. There could be some bias because interviewees talked from their point of view. Due to the language and cultural differences, respondents might have not revealed all what they were thinking or intended to say in their native language (in most cases – Norwegian).

Secondly, the sampling in the research was a challenging part. Tight GPs' schedules made it impossible to enhance the sample scope to a greater extent. Participation in the research included only 15 respondents (8 GPs, 5 staff members from the Oslo KAD, 2 respondents were interviewed for data triangulation purposes). Moreover, respondents often mentioned other municipalities' in Norway. However, the research lacks opinions from other municipalities for the purpose of comparison.

Thirdly, although the research was performed carefully, and validity and reliability (cf. Chapter 4.2) were checked thereafter to the most accurate extent in order to test trustworthiness of the

results, the sampling of GPs embraced only 4 city districts<sup>8</sup>. However, due to the fact that the Oslo KAD started its operation as late as 2013, it was assumed that this will not have a deteriorating effect upon the results.

Fourthly, among the GPs there were very few doctors who referred patients to the Oslo KAD and had any opinion and/or experience about the referral process. This bias could have the impact on the research results, but due to the abovementioned novelty of the Oslo KAD and the triangulation of the data it was assumed that the healthcare organization in Oslo has the major impact to the GPs activity in referrals, not their previous experience.

Furthermore, 1 out of 5 staff members in the Oslo KAD sample was working at the Oslo emergency ward. This means that respondent's answers might have been impacted by his work practice at the emergency ward. To minimize this bias, I asked the respondent prior to the interview to talk as a staff member from Oslo KAD only.

Pressman and Wildavsky's assumptions as well as van Meter and van Horn's approach suit the model, intentions and goals which I have formulated in this master thesis. Establishment of KADs in Norway was just a part of the Coordination Reform. Therefore I have chosen to look through a more general prism. However, the use of purely bottom-up or top-down approaches might have yielded different results, especially when the overall implementation of the Coordination Reform was to be evaluated.

Furthermore, with this research I intended to analyze the implementation of the Oslo KAD through the Implementation Theory only. Therefore, the use of a wider theory could also be regarded as limitation of the thesis.

Finally, the insights from the samples in the Oslo KAD could have some bias too in terms of their attitudes (presumably positive) towards organization they are working at. Due to that their attitudes were taken for granted with great caution.

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<sup>8</sup> 5 GPs were interviewed in Østensjø, other 3 in Grünerløkka, Nordre Aker and St. Hanshaugen.

## 7 Conclusion

This qualitative research is the first one which explores the policy implementation of the KAD in Oslo in terms of patients' referrals. The results of the research demonstrated that the implementation of the KAD had proceeded in a different way than it was expected.

Following analysis of the reasons why general practitioners refer patients to the Oslo KAD at lower rates than expected, the study investigated different factors that lead to such situation. The Oslo KAD regards GPs as a good source of patient admissions, whereas GPs struggle with the organizational structure of primary healthcare which is different from that in smaller municipalities of Norway, with the lack of information, logistical problems and, in general, novelty of the KAD concept. These factors operate as direct reasons why the Oslo KAD has not been implemented as intended by the Coordination Reform. Furthermore, the findings revealed that the present situation does not fulfil 3 out of 4 assumptions of the Implementation Theory, which are the main obstacles for a proper policy implementation.

Moreover, this study could be seen as a good starting point for the future researches of the Coordination Reform from the perspective of the Implementation Theory. Further studies, whether qualitative or quantitative, may encompass different regions of Norway, comparison between the most densely and most sparsely populated areas (or the biggest cities in Norway). Furthermore, a broader quantitative research regarding this topic would also facilitate the KADs, which as yet are in the implementation phase.

Finally, further researches regarding the implementation of the Coordination Reform might prove to have a supportive role in the present and future healthcare policy making, the main goal being to demonstrate the importance of keeping policy and implementation in a close relationship.

# References

- Baaske, M., Bringedal, K. H., Halvorsen, H. E., & Torgersen, H. (2013). *Kommunalt øyeblikkelig hjelp døgntilbud - Kartlegging av status og erfaringer ved etablering i norske kommuner som et ledd i samhandlingsreformen*. Oslo. Retrieved January 7, 2014, from [http://www.ks.no/PageFiles/54111/FoU-rapport\\_134018\\_%C3%98yeblikkelig%20hjelp%20d%C3%B8gntilbud%20i%20kommunene.pdf?epslanguage=no](http://www.ks.no/PageFiles/54111/FoU-rapport_134018_%C3%98yeblikkelig%20hjelp%20d%C3%B8gntilbud%20i%20kommunene.pdf?epslanguage=no)
- Babbie, E. (2013). *The Basics of Social Research*. Cengage Learning. Retrieved March 10, 2014
- Box-Steffensmeier, J. M., & Brady, H. E. (2008). *Oxford Handbook of Political Methodology*. Oxford: Oxford University Press. Retrieved February 14, 2014
- Creswell, J. W. (2002). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. Hentet March 27, 2014
- Creswell, J. W. (2014). *Research design: Qualitative, Quantitative and Mixed Methods and Approaches* (4th ed.). Sage. Retrieved January 13, 2014
- Dalen, M. (2004). *Intervju som forskningsmetode : en kvalitativ tilnærming*. Oslo: Universitetsforlaget. Hentet November 13, 2013
- deLeon, P., & deLeon, L. (2002). What Ever Happened to Policy Implementation? An Alternative Approach. *Journal of Public Administration Research and Theory*, 12(4), 467-492. Retrieved January 18, 2014, from <http://jpart.oxfordjournals.org/content/12/4/467.full.pdf+html>
- Den Norske Legeforening. (2013). *Veileder til utarbeidelse av avtalerom bemanning av kommunalt akutt døgnopphold (KAD)*. Oslo: Den Norske Legeforening. Retrieved January 8, 2014, from <http://legeforeningen.no/PageFiles/143698/Veileder%20til%20utarbeidelse%20av%20avtaler%20om%20bemanning%20av%20kommunalt.pdf>
- Det Kongelige Helse- og omsorgsdepartement. (2008-2009). *St. Meld. 47. Samhandlingsreformen: Rett behandling – på rett sted – til rett tid*. Retrieved February 19, 2013, from Regjeringen: <http://www.regjeringen.no/pages/2206374/PDFS/STM200820090047000DDDPDFS.pdf>
- Det Kongelige Helse- og omsorgsdepartement. (2011, April 8). *Helse- og omsorgsdepartementet*. Retrieved January 18, 2014, from Meld. St. 16 (2010–2011) Nasjonal helse- og omsorgsplan (2011–2015):

- <http://www.regjeringen.no/nb/dep/hod/dok/regpubl/stmeld/2010-2011/meld-st-16-20102011.html?id=639794>
- Fastlegen.no. (2014). *Fastlegen.no. Din nærmeste helsehjelp*. Retrieved January 11, 2014, from Fastleger i Oslo: <http://www.fastlegen.no/alle-fastleger/oslo?page=7&query=>
- Gibbs, G. (2007). *Analyzing qualitative data*. Thousand Oaks: Sage. Retrieved January 20, 2014
- Golafshani, N. (2003, December). Understanding Reliability and Validity in Qualitative Research. *The Qualitative Report*, 8(4), 597-607. Hentet April 14, 2014 fra <http://www.nova.edu/ssss/QR/QR8-4/golafshani.pdf>
- Hagen, T. P., & Kaarbøe, O. M. (2004). *The Norwegian Hospital Reform of 2002: Central government takes over ownership of public hospitals* (Vol. 1). Oslo: University of Oslo. Retrieved November 23, 2013, from [https://www.duo.uio.no/bitstream/handle/10852/30303/HORN\\_2004\\_1.pdf?sequence=1](https://www.duo.uio.no/bitstream/handle/10852/30303/HORN_2004_1.pdf?sequence=1)
- Helse- og omsorgsdepartementet. (2009, Juni 9). *St.meld. nr. 47. Samhandlingsreformen. Rett behandling – på rett sted – til rett tid*. Hentet March 22, 2014 fra Regjeringen: <http://www.regjeringen.no/nb/dep/hod/dok/regpubl/stmeld/2008-2009/stmeld-nr-47-2008-2009-.html?id=567201>
- Helse- og omsorgsdepartementet. (2011, June 24). *Lov om folkehelsearbeid (folkehelseloven)*. Retrieved January 18, 2014, from Lovdata: <http://lovdata.no/dokument/NL/lov/2011-06-24-29>
- Helse- og omsorgsdepartementet. (2011, June 24). *Lov om kommunale helse- og omsorgstjenester m.m. (helse- og omsorgstjenesteloven)*. Retrieved January 18, 2014, from Lovdata: <http://lovdata.no/dokument/NL/lov/2011-06-24-30>
- Helse- og omsorgsdepartementet. (2012, August 29). *Forskrift om fastlegeordning i kommunene*. Retrieved January 12, 2014, from Lovdata: <http://lovdata.no/forskrift/2012-08-29-842/§12>
- Helse- og omsorgstjenesteloven*. (2011, June 24). Retrieved January 12, 2014, from Lovdata: [http://lovdata.no/dokument/NL/lov/2011-06-24-30#KAPITTEL\\_3](http://lovdata.no/dokument/NL/lov/2011-06-24-30#KAPITTEL_3)
- Holzer, M., & Schwetser, R. W. (2011). *Public administration: An Introduction*. London: M.E. Sharpe. Retrieved January 19, 2014, from <http://books.google.no/books?id=fmgzqaFE1FQC&printsec=frontcover#v=onepage&q&f=false>

- Hupe, P. (2011). The Thesis of Incongruent Implementation: Revisiting Pressman and Wildavsky. *Public Policy and Administration*, 26(1), 63-80.  
doi:10.1177/0952076710367717
- (2014, March 3). Interview with the respondent from the Emergency ward in Oslo. (I. Kairys, Interviewer)
- (2014, February 13th). Interview with the respondent from the Oslo KAD. (I. Kairys, Intervjuer) Hentet March 28, 2014
- Johnsen, J. R. (2006). Health Systems in Transition: Norway. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies. Retrieved November 21, 2013
- Kjellberg, F., & Reitan, M. (1997). *Studiet av offentlig politikk: En innføring*. Oslo: Tano. Retrieved February 27, 2014
- (2013). *KS FoU-prosjekt nr. 134018: Øyeblikkelig hjelp døgntilbud i kommunene*. Oslo: Deloitte. Hentet January 16, 2014 fra <http://www.ks.no/tema/Innovasjon-og-forskning1/Forskning-og-utredning/Ferske-FoU-rapporter/FoU-Oyeblikkelig-hjelp-dogntilbud-vokser-fram-i-norske-kommuner/>
- Kumar, R. (2011). *Research methodology* (3rd ed.). London: SAGE publishing. Retrieved February 25, 2014
- Moxness, L. –E., Westermann, A. H., Kristiansen, L. I., Sommer, M., Angen, S., & Fiskum, E. (2012). *Øyeblikkelig hjelp døgnopphold*. Retrieved January 24, 2014, from <http://www.midtre-namdal.no/rapport-vedroerende-lovkrav-om-dogntilbud-i-kommunene-ved-oyeblikkelig-hjelp.5070924-197762.html>
- Neena, S. (2011). Research methods and statistics. University of Calicut. Hentet May 1, 2014 fra [www.universityofcalicut.info/.../Research\\_methods\\_statistics.pdf](http://www.universityofcalicut.info/.../Research_methods_statistics.pdf)
- Oslo kommune. (2011, November 13). *Kommunal akutt døgnenhet (KAD) på Aker*. Retrieved January 11, 2014, from Oslo kommune. Helseetaten: <http://www.helseetaten.oslo.kommune.no/kad/>
- Oslo kommune. (2012). *Kommunal Akutte Døgnopphold. Prosjektrapport Fase 1*. Oslo. Hentet fra [http://www.helseetaten.oslo.kommune.no/getfile.php/byrådsavdeling%20for%20velferd%20og%20sosiale%20tjenester%20\(VST\)/Internett%20\(VST\)/Dokumenter/sluttrapport%20fase%201.pdf](http://www.helseetaten.oslo.kommune.no/getfile.php/byrådsavdeling%20for%20velferd%20og%20sosiale%20tjenester%20(VST)/Internett%20(VST)/Dokumenter/sluttrapport%20fase%201.pdf)
- Oslo kommune. Helseetaten. (2013, November 11). *Følgende pasientgrupper er aktuelle for KAD*. Retrieved January 8, 2014, from Oslo kommune: [http://www.helseetaten.oslo.kommune.no/kad/aktuelle\\_pasientgrupper/](http://www.helseetaten.oslo.kommune.no/kad/aktuelle_pasientgrupper/)



- Oslo kommune. Helseetaten. (2013). *Kommunal akutt døgnenhet*. Oslo: Oslo kommune. Hentet March 22, 2014 fra [http://www.helseetaten.oslo.kommune.no/getfile.php/Helseetaten%20\(HEL\)/Internett%20\(HEL\)/Dokumenter/Faktaark%20til%20%C3%A5pningen.pdf](http://www.helseetaten.oslo.kommune.no/getfile.php/Helseetaten%20(HEL)/Internett%20(HEL)/Dokumenter/Faktaark%20til%20%C3%A5pningen.pdf)
- Oslo universitetssykehus. (2011, February 8). *Kart over Oslo*. Retrieved January 12, 2014, from Oslo universitetssykehus: <http://www.oslo-universitetssykehus.no/fagfolk/veiviseren/sider/kart-over-oslo.aspx>
- (2012). *Øyeblikkelig hjelp døgnopphold*.
- Ploeg, J. (1999). Identifying the best research design to fit the question. Part 2: qualitative designs. *Evid Based Nursing*(2), ss. 36-37. doi:<http://ebn.bmj.com/content/2/2/36.full>
- Pressman, J. L., & Wildavsky, A. (1973). *Implementation: How Great Expectations in Washington are Dashed in Oakland*. Los Angeles: University of California Press. Retrieved January 21, 2014
- Pressman, J. L., & Wildavsky, A. (1983). *Implementation: How Great Expectations in Washington are Dashed in Oakland*. University of California Press. Retrieved February 25, 2014
- Pülzl, H., & Treib, O. (2007). Implementing Public Policy. In F. Fischer, & G. J. Miller, *Handbook of Public Policy Analysis: Theory, Politics, and Methods* (pp. 89-107). CRC Press. Retrieved March 26, 2014
- Ringard, Å., Sagan, A., Saunes, I. S., & Lindahl, A. K. (2013). *Norway: Health system review. Health Systems in Transition*. Copenhagen: The European Observatory on Health Systems and Policies. Retrieved January 11, 2014, from [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0018/237204/HiT-Norway.pdf](http://www.euro.who.int/__data/assets/pdf_file/0018/237204/HiT-Norway.pdf)
- Rubin, A., & Babbie, E. (2008). *Essential Research Methods for Social Work*. Cengage learning. Retrieved March 10, 2014
- Sletvold, B. (2014, January 8). *Kommunal Akutt Døgnenhet. Utvikling gjennom 2013. Report*. Oslo. Retrieved January 8, 2014
- Snøfugl, G. (2013). *Status for kommunalt døgntilbud for øyeblikkelig hjelp - notat*. Helsedirektoratet, Avdeling økonomi og analyse, Oslo. Retrieved January 18, 2014, from <http://www.helsedirektoratet.no/finansiering/okonomiske-virkemidler-i-samhandlingsreformen/oyeblikkelig-hjelp-dogntilbud/Documents/Status%20for%20kommunalt%20dognstilbud%20for%20oyeblikkelig%20hjelp.pdf>
- Statistics Norway. (2014). Tabell: 05869: Flyttinger fra og til utlandet. Oslo. Retrieved February 2, 2014

Statistics Norway. (2014). Tabell: 07457: Fastleger, etter innvandringskategori (F). Oslo.  
Retrieved February 2, 2014

Statistisk Sentralbyrå. (2013, November 21). *Folkemengd 1. januar og endringane hittil i år. Heile landet, fylke og kommunar*. Retrieved November 21, 2013, from Statistisk Sentralbyrå: <http://www.ssb.no/befolkning/statistikker/folkendrkv/kvartal/2013-11-21?fane=tabell&sort=nummer&tabell=149691>

Van Meter, D. S., & Van Horn, C. E. (1975). The Policy Implementation Process: A Conceptual Framework. *Administration & Society*, 445-488. doi: 10.1177/009539977500600404

Yin, R. (2009). *Case Study Research: Design and methods* (4 ed.). Thousand Oaks: Sage.  
Retrieved January 20, 2014

Yin, R. K. (2014). *Designing Case Studies: Identifying Your Case(s) and Establishing the Logic of Your Case Study*. SAGE Publications. Hentet April 14, 2014 fra [www.sagepub.com/upm-data/24736\\_Chapter2.pdf](http://www.sagepub.com/upm-data/24736_Chapter2.pdf)

# Appendices

## Appendix A

### Request for participation in the research project

#### *“General practitioners' activity in patient referrals to the Oslo KAD”*

#### **Background and object**

The purpose of this research project within framework of the master thesis being held at the University of Oslo is to investigate why general practitioners (hereinafter – GP) in the Oslo municipality avoid referring patients to the 24-hour immediate help health care services (in Norwegian - Kommunalt Akkut Døgnopphold) ?

You are invited to participate in this project as the sample will consist of the relevant staff members in Oslo Kommunalt Akkut Døgnopphold (hereinafter - Oslo KAD) and some general practitioners (hereinafter – GP) in Oslo municipality.

#### **The purpose of the project and what the information will be used for**

The purpose of this project is to collect, analyze and compare different opinions and insights from both Oslo KAD and the GPs regarding patient referrals to the Oslo KAD. The semi-structured interviews would be held at the time and place suggested by you and recorded with an audio device for the qualitative data analysis purposes. It would take approximately 20-30 minutes.

#### **What will happen with information about you?**

All the information will be kept confidential. Only the student and supervisor will have access to the collected information. Audio recordings taken by an audio device will be stored, kept and processed using password protected personal computer. As soon as the research is finished, all the audio recordings will be deleted. The respondents in this project will not be directly identified.

The project is planned to be finished in June 2014. During the research all the semi-structured interviews will be recorded using an audio device and data will be analyzed with PC. Audio recordings will be deleted after the project is finished.

#### **Voluntary participation**

Participation in this project is voluntary and the participants may withdraw their consent during the project in progress, without stating the reason.

To learn about your willingness to participate I will contact you within 5 days after you receive this letter. Otherwise, if you are sure you want to participate in the project please contact me, Irvinas Kairys, by phone +4796675879 or e-mail [irvinas.kairys@studmed.uio.no](mailto:irvinas.kairys@studmed.uio.no)

The project has been reported to the Data Protection Official for Research at the Norwegian Social Science Data Services.

#### **Consent for participation in the study**

I have received written information and I am willing to participate in the project

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(Signature of the respondent, date)

## **Appendix B**

### **Interview Guide**

- What are your duties/responsibility/involvement regarding the coordination reform?
- Insights about the Oslo KAD. Does it/how it create additional value for the health care system?
- Insights about patient referrals to the Oslo KAD. For example, what are pros and cons of this?
- What are the possible reasons of low rates of patient referrals from GPs to the Oslo KAD?
- How could the situation be improved?