LEADERS APPROACH TO SICKNESS ABSENCE

"How does restructuring affect sickness absence and how do managers approach sickness absence resulting from such changes"?

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and

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"It is not the strongest of the species that survives, nor the most intelligent, but rather the one that is most adaptable to change"

(Charles Darwin)

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Abstract

Title: Leaders Approach to Change

Background: The healthcare sector is large and complex with high rates of organizational change. Previous studies have linked negative employee outcomes such as increased rate of sickness absence with organizational change in mainly the specialist health care sector. Therefore the focus of this paper has been at middle managers in primary health care institutions. It is important to find out how to reduce sickness absence in the primary health care sector for several reasons: it already has a high level of sickness absence, it employs many people, and third, sickness absence will continue to increase if we do not take initiatives to prevent sickness absence.

Aim of the study: We have chosen a two-parted problem, with a theoretical part and an empirical part, respectively: "How does restructuring affect sickness absence? Which approach do managers take when handling sickness absence resulting from such changes"?

Method: The thesis is a qualitative study based on semi-structured interviews with 16 middle-managers in the Nursing Administration in Oslo.

Results: We found that uncertainty and lack of information increases the risk of sickness absence in a change process. The managers who had great comprehension of the Valley of Despair model felt that they had a better chance of success during uncertain events. Most of the managers had a transformational approach towards managing. They used individualized consideration for all their employees and focused more on trust and support. According to previous research, theories, and our findings, supportive management is valued by the employees and is indicated to be necessary for preventing sickness absence. Some had a more strict way of leading with use of reward and punishment, which leans toward a transactional approach. This could lead to a "scare culture", which they thought could prevent sickness absence. It is important to know how to approach sickness absence and increase knowledge about change processes. Almost every leader emphasized the phrase "from absence to presence", where they wanted to change the focus for sickness absence by focusing on the present employees instead of those absent. They did not mention professional development for the employees as a means to get more motivated employees to the degree we expected. Rather, they focused on creating a better work environment by taking different initiatives such as ensuring adequate information.

Conclusion: Supportive management and motivation in combination with adequate information is necessary for a successful change process.

Acknowledgement

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This thesis has been written as part of the master program in Health Economics, Policy and Management at University of Oslo, with a specialization in Management. It has been thrilling to learn more about organizational change and sickness absence from a management perspective. The knowledge we achieved through this program before writing the thesis has been helpful and much appreciated during the writing process. We believe that this knowledge is going to help us in our management careers. As John Heywood said, "many hands make light work," and we have several hands to thank.

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Gitte and Michelle.

Table of Content

1 Introduction

High percentage of sickness absence is a tremendous challenge in the healthcare sector (Arbeidsmiljøutvalget, 2015; SINTEF, 2014; Fevang, 2003). The sickness absence rate in the healthcare sector is higher than average rates of absence in other sectors (Fevang, 2003). This sector also has a high rate of organizational change—given these two facts, we want to understand why this happens and what middle managers can do to mitigate the problem (Oslo kommune, 2015; Kjekshus, Bernstrøm, Dahl & Lorentzen, 2014). When the Coordination Reform was implemented in 2012, the primary health care providers in Norway had to restructure their health care services to meet the new demands. With increasing demands on the primary health care sector, the need for more competent leaders emerges. When the primary health care sector are expanding and take on more tasks from the specialist health care sector they are more or less in a change process all the time which requires improved competence. If the leaders know what happens with the employees in this process they can make better informed decisions. They have to understand a complexity within higher demands, more advanced tasks and uncertainty and this is the reality for the leaders in the primary health care sector every day (Regjeringen, 2012; Regjeringen, 2015b). The cost of sickness absence for the society, the administration, the employees and the patients is extremely high, so if the manager can reduce these costs everyone would benefit from this (SINTEF, 2014).

This study considers the connection between: 1. restructuring of the organization and 2. short-term and long-term sickness absence. Focus on both of these aspects will provide a more detailed and complex picture of why organizational changes increase the rate of sickness absence and what approach managers take to mitigate the problem. We will look at what kind of approach the leaders take in the process of a change. We will look at what strategies they used to decrease sickness absence in the change process and which approach they think is optimal. There is a knowledge gap in how the managers handle this problem in the primary health care sector. Research on middle managers in the primary health care sector and their approach to sickness absence is therefore necessary. The aim for this study is to find out what managers are currently doing and what else they can do to decrease the sickness absence among their employees.

The focus is at how the managers approach sickness absence when there is an organizational change and how the managers experience this, which makes this into a qualitative study. The relevance of the study is that it will hopefully provide managers a better understanding about sickness absence and change. The study has potential benefits of informed decision-making and increased understanding of why some employees react negatively or positively to change, and how managers' can manage these effects. We can get an increased understanding of mechanism of change, discover patterns, understand more about the nature of the phenomenon being studied and identify concepts and theory (Justesen & Mik-Meyer, 2012). The result of this study can be transferred to different sectors, not only the healthcare sector, and can be applied to almost every worker. It can also be applicable at the different management levels, not only by middle managers (Kjekshus, 2014a).

1.1 The Aim of the Study

"How does restructuring affect sickness absence and how do managers approach sickness absence resulting from such changes"?

We have chosen to have a two-parted problem, with a theoretical part and an empirical part:

1. How does restructuring affect sickness absence?
2. Which approach do managers take when they handle sickness absence resulting from such changes?

1.2 Co-writing the Thesis

The thesis has been written in cooperation and we were both part of writing theory, method, the collecting of data, discussion and conclusion. The carrying-out of the project was done together. Both of us have helped each other out, meaning that none of the parts was done completely individually. There have been discussions on every topic throughout the process and both have been involved in decision-making regarding what to include and how to conduct the discussion and conclusion.

1.3 Concepts, Key Terms and Abbreviations

1.3.1 Change

Change management is currently trending, and some even argue that all management today is change management (Hennestad, 2012). Hennestad and Revang (2012) say that change management is to lead planned and controlled changes in organizations. “Restructuring is a planned and intentional change in an organization’s formal structure, systems and processes to improve the organization’s realization against one or more targets” (Lines, 2005, p. 2). One has to implement a new reality. This affects the manager’s focus, structures and processes (Hennestad & Revang, 2012). We will use the words change and restructuring interchangeably.

An organizational change can be divided into process and content, where the process is how the change is done and content is what the change is about (Barnett & Carroll, 1995). To be aware of this can make it easier to see what the consequences of the change actually are. That means when looking at sickness absence we can separate what the effect is from the change itself and from the process of the change. That makes it possible to see to what extent the effect on sickness absence is coming from the content of the change and to what extent the effect is coming from the implementation of the change (Barnett & Carroll, 1995). The focus of this study is the process of the change and how the manager can affect it. The process of the change usually requires extra work and effort in addition to the normal work tasks and often without extra resources. A change process might cause an uncertain situation for the employees as well as extra workload, which can affect the work environment and also increase the risk of sickness absence (Robinson & Griffiths, 2005).

We can differentiate between three different kinds of change: the emergent, the periodic, and the continuous change. Change can also be described as either planned or unplanned (Iles & Sutherland, 2001; Kjekhus et al., 2014). Most of the changes we will look at are planned, however, all planned changes have some elements of unplanned factors in them because of uncertainty. This uncertainty comes from factors that are out outside the manager's control, such as financial and political pressure, or within the organization where different interests may conflict. Periodic change is more radical and intentional where something is replaced with something new, e.g. creating or replacing an institution. Continuous changes are evolving, new ideas are constantly picked up from several places and used; many of these changes at once can result in a big change. These categories are not mutually exclusive and the change an organization goes through can have elements of all three. Most of the changes

our participants went through were primarily periodic, but there were also a few cases of continuous changes turning into bigger changes over time (Iles & Sutherland, 2001).

According to Lewin there are three stages of change: unfreezing, moving and refreezing (Iles & Sutherland, 2001). For a change to happen it is important to unfreeze the organization so that the restraining forces will not cause resistance to the change. The next stage is moving, in which new routines are implemented and learned. The last stage, refreezing, is the stage where the new change becomes the norm (Schein, 1996). Several previous research projects talk about changes within this framework. The rate of sickness absence is very often highest at the moving and refreezing stages. Only a few studies report problems beginning in the unfreezing stage (Kjekshus, 2014a; Hansson, Vingård, Arnetz & Anderzen, 2008; Josephson, Lindberg, Voss, Alfredsson & Vingård, 2008; Bourbonnais, Brisson, Malenfant & Vezina, 2005). Most organizations never reach the refreezing stage because even newer change processes are implemented and unfreezing begins again. Studies of organizational change are therefore necessary to make change processes more successful (Schein, 1996).

1.3.2 Sickness Absence

Long-term sickness absence is defined as an absence longer than 16 days due to mental and/or physical ill health (Kjekshus et al., 2014). Long-term sickness absence needs to be certified by a doctor. Short-term sickness absence is defined as absence shorter than 16 days. Normally the employees can take 3 day sick leave without going to the doctor for certification. Some organizations, called “IA-virksomhet”, limit short-term absence to 8 days. This paper will focus on one such IA-virksomhet organization when considering uncertified short-term absence (Oslo kommune, 2015; Inkluderende Arbeidsliv, 2015). Sickness absence will be explained more thoroughly later in this paper.

1.3.3 Employees in Sykehjemsetaten (SYE)

Middle managers in SYE, the Nursing administration, are responsible for nurses, nurse assistants and assistants. These are three different groups. While nurses and nurse assistants have authorization as health care personnel from “Statens autorisasjonskontor” (SAK), the assistants are not authorized. Authorization as a nurse requires at least a three year bachelor degree, whereas nurse assistants require a specific trade certificate. The assistants have no formal training but often have local training (Statens autorisasjonskontor, 2015).

1.3.4 Management and Leadership

Leadership can refer to those both with and without formal authority and makes it possible for individuals and groups to work together in a meaningful way. To be a leader has traditionally been perceived as a trait and quality only a few people have (Spehar, 2014). "Leadership is a process through which an individual attempts to intentionally influence human systems in order to accomplish a goal" (Buchbinder & Shanks, 2011 p.128). Leadership is related to but distinct from management. Management focuses on performance in managerial roles and is position and organization-specific (Spehar, 2014). "We can describe it [the managerial role] as art, informed by science and uniquely applied in the context of organizational and personal experience" (Buchbinder & Shanks, 2011 p.47).

Burns, Bradley and Weiner (2012) say that while these terms are often mixed together, it is important to know one difference: management is concerned with the execution of action to achieve goals while leadership is concerned with setting the goals. Leadership is therefore in a way more visionary and management more administrative. We will use the words management and leadership interchangeably henceforth, as both activities are usually integrated in formal management positions. There are different levels of management in the primary health care organization: front-line managers, middle managers and top managers. Our study focuses on middle managers who have responsibility for entire departments within the health care organization. Middle managers comprise a majority of all managers in the healthcare sector. Middle managers face cross-pressure from the top and bottom simultaneously, which is often a big challenge. The middle managers are strategically the front-line of change management (Burns et al., 2012).

1.3.5 Acronyms

SYE	Nursing administration
NAV	Service for financial and social safety
IA	Including work environment
HMS	Health, environment and safety

VO	Safety representative
BHT	Business health organization
AAP	Work assessment allowance
HR-system	Human relation system
TV	Union representative
SAK	The Norwegian registration authority

1.3.6 Structure and Delimitation

Including the introduction, this thesis is divided into 9 chapters. The second chapter provides information about the background and previous studies about sickness absence and change. The third chapter is about the structure of the healthcare sector and is divided into subchapters about the Coordination Reform, the nursing administration and IA. In the fourth chapter we define sickness absence and provide an understanding of sickness absence. Further we explain why organizational change increases sickness absence and we provide statistics about sickness absence and health care workers. Lastly in this chapter we include legal framework that the managers need to adhere to when handling sickness absence. The fifth chapter describes the theoretical and analytical approach we have chosen. The sixth chapter deals with study design. The seventh chapter presents results and findings from the interviews. The eighth chapter contains a summary of the main findings, general discussion, and methodological considerations well as possibilities for future research. The ninth and final chapter offers the conclusion of the thesis.

There are several previous research projects that have focused on management and change and management and sickness absence, but there are few projects that consider change and sickness absence simultaneously. Our goal is to look at how middle managers in the primary health care sector, more precisely SYE, approach sickness absence in a change process.

2 Background

The healthcare sector is large and complex with high rates of organizational change. New management theories consider the high complexity of its organizations. This new view on organizations started in the 1990's and describes organizations as "dynamic, nonlinear systems that operate at the edge of chaos" (Burns et al., 2012, p. 216). The reason for this new perspective is changing demand from the population coming from, among other things, changing demographics and diseases. The life expectancy in Norway is increasing along with percentage of chronically ill people (Store medisinske leksikon, 2014). When there is a change in the demand of health care, the politicians introduce policy changes and reforms. New technology, treatments and medicine are also affecting how healthcare is provided and organized. Costs are increasing at a faster rate than wealth creation, which forces the healthcare sector to become more efficient and use all resources in the best way possible (Burns et al., 2012). Hospitalization times have decreased in the last decade while daytime treatments have increased. All of these factors play a role in shaping and reshaping the healthcare sector. There is especially high pressure and scrutiny on the healthcare sector from the society, because this is something that affects everyone in one way or another (Kjekshus, 2014b).

Sickness absence influences the economy, society, health care sector, quality in the healthcare sector, policy, education sector and others. As previously stated, the healthcare sector is large and complex with high rates of organizational change. The cost of sickness absence is extremely high: one week of sickness absence costs about 14 600 Norwegian kroner, excluding the salary costs. This number is from a 2014 study by SINTEF which looked at production loss and expenses for temps, overtime, and more. Half of the expense was used on temps and overtime alone. A sudden absence will have large consequences for quality of care in the short term, but after some time the organization will set in compensating measures that will reduce the consequences (SINTEF, 2014). SINTEF (2011) refers to a master thesis that made a cost model for nursing homes in 2004. The conclusion is that the main cost driver of sickness absence is temp costs, administrative costs, reduction in salary- and social costs, both physical and psychological strain on the employees, deterioration of psychosocial and physical environment, loss of quality of life for the patient, worsened condition for the patient, reduced attendance and service level all of which contributes to more absent employees.

It is important to find out how to reduce the sickness absence in this sector for several reasons: it already has a high level of sickness absence, it employs many people and third, it will keep increasing. The new framework called “Fra fravær til nærvær” addresses the cause of high rates of sickness absence in the primary health care sector. Rates of sickness absence vary greatly between different nursing homes, both within and across the municipalities studied. The financial situation in the municipality and resources distributed to nursing homes can then not always be blamed for sickness absence. By looking at the differences in sickness absence in different nursing homes it is possible to look closer at the places with low absence rates and ask what the managers do differently. The results indicate that the managers in the nursing homes with lowest rates of sickness absence made an effort to figure out what caused the sickness absence with dialogs and creating openness at work. This gives the impression that something can be done to mitigate the problem and that we do not need to settle for this high absence rate (Bogen & Lien, 2015).

2.1 Previous Studies

Previous studies have linked negative employee outcomes such as increased rate of sickness absence with organizational change. Organizational change often means increased uncertainty, higher workload and more stress for the employees (Vakola & Nicolaou, 2005). A study done by Kjekshus and colleagues (2014) shows significant increase in sickness absence immediately after informing the employees about a merger process, with continually increasing absence in the years during and following the merger. Uncertainty at work causes negative stress, which can have both immediate and long-term effects. Negative stress leads to unsatisfied employees in the present while long term effects are that employees does not perform optimally and are less committed to their jobs. It may also affect the physical and mental health of the employees (Head, Kivimäki, Martikainen, Vahtera, Ferrie and Marmot, 2005). A Swedish study from 2008 also showed results of higher sick leave during organizational change, especially among assistant nurses and nurses over 50 years old working in geriatric care (Josephson et al., 2008). The same study also showed an increased rate of nurses that ended their employment to escape unwanted work conditions. Nurses felt less involved in their work in a Canadian study, which also showed increased rates of depression, anxiety, emotional exhaustion and work insecurity (Kjekshus, 2014a; Hansson et al., 2008; Josephson et al., 2008; Bourbonnais et al., 2005).

3 Structure of the Health Care Sector

Norway's health care services can be divided into primary and secondary care and are both financed primarily by the government with only a small deductible for primary care. The secondary care is provided by specialists and given in the hospitals, either as single day-treatment or longer hospitalization. The secondary care is owned, financed and controlled by the government in Norway and consists of somatic and mental health services and also specialized drug-abuse treatment. To have a well-functioning health care system it is important that there is a good and efficient cooperation between these two care providers (Helsedirektoratet, 2014; Helsedirektoratet, 2015).

The primary health care sector is run by the municipalities and consists of several services: general practitioners, both with emergency and scheduled services, mental health, school nurses, home care services and nursing homes. The municipalities have received more responsibility after the implementation of the Coordination Reform, which is explained thoroughly in subsequent sections. This has led to changes in the delivery of primary health care and how it is organized. It is the municipalities' responsibility to make sure that everyone in need of health care services receives them at an appropriate level of care. The number of residents in the permanent nursing homes has been stable the last 5 years, in part because it has become more common to live at home longer. The effect of this trend is that the majority of the residents in permanent nursing homes are now older, over 80 years of age, and often in poorer average health than residents in previous years (Helsedirektoratet, 2015). Approximately 70-85% of the patients in nursing homes have some kind of dementia or cognitive impairment. Many of them also have one or several chronic diseases, which makes treatment and medication more complicated. About half of the residents in a nursing home get pneumonia or urine infections each year. All these factors combined makes it difficult to know whether it is beneficial for the patients to go to a hospital when acutely sick or stay in the nursing home and get treatment at a lower level. It requires a certain level of competence among the nurses to make this judgment, about both acute diseases and palliative care (Ranhoff & Linnsund, 2005). Short-term care units have experienced an increased demand for services like rehabilitation, treatments and check-ups. Users of these services are typically younger than the permanent residents in nursing homes (Helsedirektoratet, 2015).

3.1 The Coordination Reform

The Coordination Reform of 2012 was implemented to increase and improve the cooperation between the primary and secondary health care. The goal was to improve the health of the population by providing health care services faster and closer to people's homes while also preventing more diseases. The Coordination Reform seeks to improve the preventative care by helping people to become more active, eat healthier and quit smoking. It has, however, been necessary to make changes in the supply of primary health care services to achieve these new goals (Helsedirektoratet, 2015). Patients were given new opportunities to receive health care better suited to them at the right place and time, to be achieved through the improved cooperation between primary and secondary care. This is very important when the patients are treated at several places, transferring between hospitals and different departments inside the hospital. Good cooperation and collaboration in local medical centers can contribute to meet the demand for the reform.

The collaboration agreement was signed July 1, 2012, but some aspects have not yet been finalized. The specialist health care and the primary health care sector have made agreements on cooperation to supply the best health service possible for the population. "Helse- og Omsorgsdepartementet" has a guide to help in this work. This agreement will ensure discharged patients at hospitals further care at an appropriate institution (helsehus or short-term unit) if necessary. Patients are not going to be admitted to the hospital if the primary health care can treat the patient. The goal is to treat patients at the lowest prudent care level. The government has to make arrangements for every medical discipline to make this happen, which the providers of health care must agree to. The parts of the agreement that are most applicable for this paper are:

- Type of health care duties different providers are responsible for and a mutual agreement on what measures to make
- Guidelines on hospitalization and discharging patients and their need for more treatment
- Reuniting emergency plans and medical pathways
- Agreements on habilitation, rehabilitation, patient education and disease management
- Description on municipality offers about hospital stay for immediate help
- Guidelines about transferring knowledge and exchange of information

- Cooperation about research, development, education and practical training (Regjeringen, 2012).

3.2 The Nursing Administration (SYE)

SYE is responsible for giving beds, rehabilitation and the best possible offer to those in need of care, all within the established political, economic and administrative framework in Oslo. The Nursing administration is the nation's largest operator of nursing homes and Oslo's second largest agency. They are constantly trying to improve the quality of the provided healthcare services by executing different projects and improving the communication between all the participants. It was decided in 2014 to divide long-term care and short-term care into, respectively, "mitt hjem" and "helsehus." The main goals were specialization of the care and moving the medical competence, meaning that the competence had to follow the patients. They are moving all the short-term units from nursing homes and making them into four helsehus. These four helsehus provide rehabilitation and short-term stay for all the residents in Oslo. All the nursing homes that do not become helsehus will provide long-term stay for the patients who need it. These institutions will look more like a home than a hospital because after moving the short-time units there will be less noise and activity. Helsehus are going to receive patients who ready to leave the hospital, but not ready to go home. The competence in these institutions needs to be more acute and specialized than in other institutions to be able to help patients to get well enough to go home in a short time. All the employees in helsehus are therefore required to have certification either as a nurse or nursing assistant (Oslo kommune, 2015).

3.2 "Inkluderende Arbeidsliv" (IA)

SYE has, in addition to projects affecting the patients directly, started to look at actions to improve their employee's health. Focusing on this will hopefully help reduce the high rate of sickness absence (Oslo kommune, 2014). SYE, as part of Oslo municipality, is an inclusive work-environment business, or IA-virksomhet. This is an agreement between the government, NHO (employee organization) and LO (labor union). The purpose is to make the Norwegian labor market more inclusive. The IA-agreement has also made sickness absence less private, as now it is a three party agreement between the government, employer and the employee. It has become more common to talk about the absence and how to prevent it

because now it is the manager's and the employee's responsibility to reduce the sickness absence (Bogen & Lien, 2015).

3.3.1 Strategies in SYE to Increase the Presence of Employees

This chapter is abstracted from SYEs own meeting with "Arbeidsmiljøutvalget".

The IA-agreement 2014-2018 builds on a tradition for cooperation and trust between governments, employees and employers. Good results are dependent on a common goal and cooperation between "tillitsvalgt" (TV), the employees and the managers. It is necessary to receive contributions from NAV of tools and supportive measures to reach this goal. The development in sickness absence is followed closely in the Nursing Administration and a multitude of activities and initiatives aiming to increase presence are either completed, underway or planned as of 2015 (Arbeidsmiljøutvalget, 2015).

Courses and seminars for managers and employees in 2015 are several. Among others, they have work-health themed conferences for all managers and selected safety representatives. Further, new employees learn about IA and HMS (health, environment and safety) at the mandatory introduction program. They also have courses in "HMS module" (a document system for health, environment and safety) for all institutional managers and executives from every nursing home. Training in work routines on the HMS basic course for managers and safety representatives is also executed. The IA-advisor of "NAV Arbeidslivssenter Oslo" participates in management meetings and IA-meetings at all nursing homes at least twice in 2015 for advice and guidance in the systematic IA efforts (Arbeidsmiljøutvalget, 2015).

The Nursing Administration has followed up the cooperation project between the Nursing Administration, NAV Oslo and NAV Arbeidslivssenter. They want a linked program for monitoring sick leave when the employee has residence in Oslo. The main goal of the project is to reduce absenteeism in SYE, so that fewer go over to "arbeidsavklaringspenger" (AAP) and disability benefits. They also want to increase the use and awareness of partial sick leave. The training organized by NAV Arbeidslivssenter has dealt with the employer's monitoring of employees, facilitation, the duty to cooperate, mental health, and adaptation to work. In addition, SYE has held IA-gatherings for TV and safety representatives about their role and responsibilities in the IA work (Arbeidsmiljøutvalget, 2015).

Each manager is responsible for getting the necessary expertise in IA and human resources management through mandatory training, HMS-courses, courses organized by NAV job center and other current IA training. Prevention and monitoring of sick leave is a middle manager's responsibility. The manager has the executive responsibility for monitoring, documenting, maintaining dialogue with and facilitating recovery and prevention for sick leave and employees who are at risk of becoming sick. It is expected that each manager comprehends and complies with the agency's current procedures for sickness absence management, Oslo municipalities regulations for monitoring of sick leave, as well as procedures and forms that can be found in "Kvalitetslosen" (a tool for procedures, acts and deviation reports) and on the intranet (Arbeidsmiljøutvalget, 2015).

Managers and VO are responsible for following up the HMS and IA objectives and action plan 2015 in collaboration with officials, BHT and NAV job center. All managers are also responsible for continuously documenting and following up sick leave, injury, accident, violence and threats in the safety module in the HR system. The close collaboration with officials, NAV, occupational health office, the service office for reduced absenteeism and other cooperation actors in sickness absence monitoring can lead to good results in the future (Arbeidsmiljøutvalget, 2015).

All protected areas must document a minimum of two completed risk analyses of the challenges in their own working environment. One of the risk assessments should relate to risk of injury in the workplace. Mapping the facilitation opportunities in the workplace is also necessary to implement possible and appropriate measures to safeguard the working environment. It is the institution managers' responsibility to ensure there will be held a minimum of two IA-meets annually at the nursing homes (Arbeidsmiljøutvalget, 2015).

3.4 "Bedrifthelsetjenesten" (BHT)

The Nursing Administration has an agreement with "Idrettens helsesenter," in which the latter is formally approved as a business health service by the Labor Inspection Agency. Idrettens helsesenter works with a big group of different professions to make sure that they provide high quality service. These professions are general practitioners, company nurses, coaches, physiotherapists, safety consultants, and psychologists to name a few. Together they focus on making a safe and healthy workplace, in which they spend time on preventative

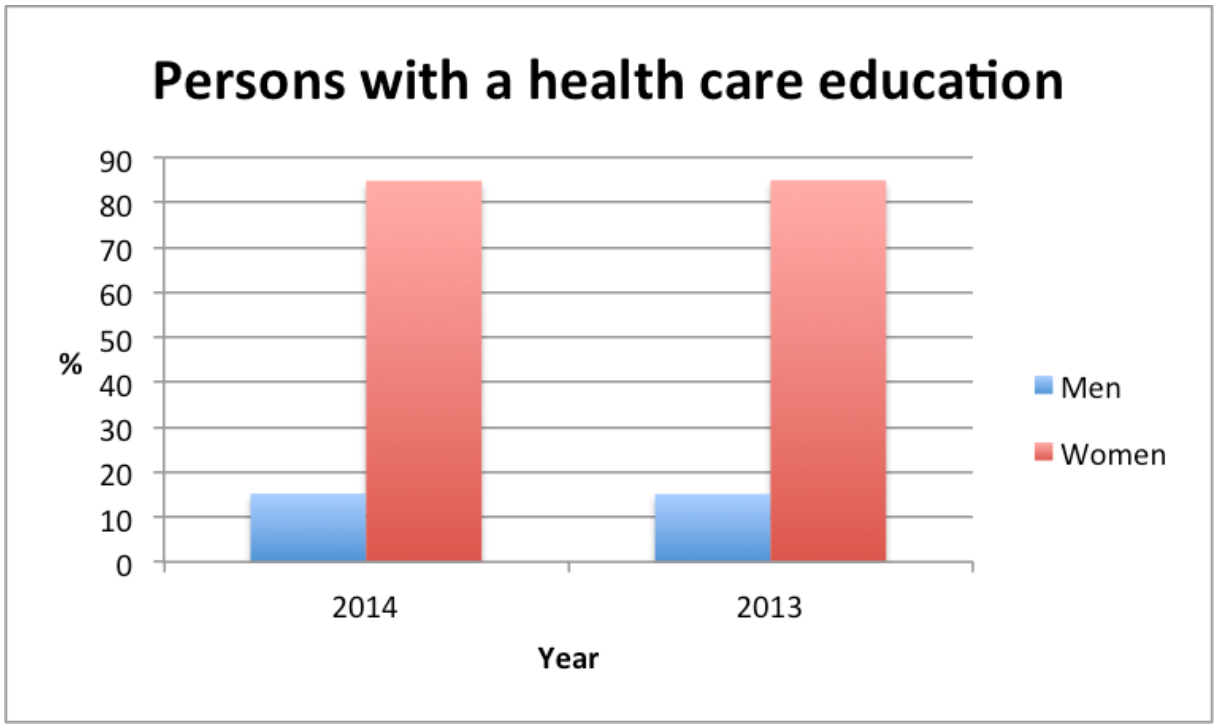
work (HMS-arbeid). All the clients have their own contact person in the Idrettens helsesenter. Some of the things they can help with are sickness absence, health at work and health screening, crisis management, psychosocial work, course tuition and working environment surveys (Idrettens helsesenter, 2015).

3.5 Health Professions in the Primary Health Care

There are several groups of employees in a nursing home: nurses, doctors, nursing assistants, physical therapists and so on. It is a challenge to manage so many different groups of employees when they all have different backgrounds and knowledge. The manager has to consider and adapt the information to be given and decide when to give it. Highly trained employees like nurses and doctors are more autonomous than nursing assistants and assistants, who need more guidance. This complicates the manager's role going between clinical leadership and administrator (Burns et al., 2012). Even though the middle managers in the primary health care are not responsible for doctors and physical therapists directly, they have to deal with and manage them indirectly. The rate of sickness absence often differs between the groups of employees in a nursing home, where the nurses have less absence than the nurse assistants (Fevang, 2003). The nurses might be more motivated to go to work, both because they have more opportunities for professional growth and also because they are more difficult to replace when sick. Nurse assistants and assistants may feel that the consequences are fewer for them to be home from work and then have a lower threshold for when they call in sick. Nurse assistants and especially assistants also have less control over their workday as well as less room for personal and professional development. It might also be because they tend to have a more physical job and often get the heaviest patients. These professions have a higher risk of getting muscular or skeletal diseases, however giving them the heaviest patients with most lifting and care is to provide the nurses time enough to do nurse-specific tasks like medication and treatment (Fevang, 2003; Bogen & Lien, 2015).

4 Understanding Sickness Absence

Norway is healthier than it has ever been; yet we also have a higher rate of sickness absence than ever (Store medisinske leksikon, 2014). Sickness absence is only correlated to a certain extent to the society's morbidity, which will be discussed later in this paper (Marmot et al., 1995). The healthcare sector has a higher percentage of sickness absence than the rest of the labor market. There are several reasons for this problem. The percentage of women working in this sector is higher than in other sectors, showed in Graph 1 below, and they normally have more sickness absence than men. Reasons for why this is can be argued, but it is assumed that it is because of physical differences and that the women often have the main responsibility at home with the family (Fevang, 2003). Fevang's study in 2003, which looked at sickness absence among healthcare workers, showed a higher rate of sickness absence in nursing homes and home care, especially among nursing assistants. She suggests the reasons for the higher sickness absence to be less control over one's own work situation, heavy lifting, and lower status associated with working with the elderly, which is typically the patient group in these institutions. Michie and Williams (2003) agree that lack of control over one's own work situation is a reason for sickness absence in addition to little decision latitude and poor/unclear management (Fevang, 2003; Michie & Williams, 2003).



Graph 1: The healthcare sector is dominated by women; there are 84 per cent women in this industry (SSB, 2015a)

Workdays for health care workers are stressful, full of uncomfortable postures and the feeling of not having enough time. Research done by the municipality shows that 36% of the participants thought that the care was not good enough in their institution because of too little time. They did not feel like they had enough time to follow the patients and start treatment early enough. The same study also showed that there are too few nurses working in nursing homes compared to unskilled workers, like assistants (Gautun & Bratt, 2014). Too few nurses at work may cause extra stress for the present nurses because they receive more responsibility and more patients to look out for. Most of the health care workers are working in an institution where they work shifts, which is more straining for the body than normal work hours (Fevang, 2003). All the changes that the healthcare sector goes through come in addition to stressful workdays. Change in the workplace is a known factor that causes more stress, especially if the employees feel insecure and get increased workload (Kjekshus et al., 2014; Michie & Williams, 2003).

There are other negative consequences in addition to the health of the employees that results from these working conditions. High percentage of sickness absence means that more people are absent from work, which increases the workload for the people present. This again can increase the level of sickness absence for those attending work. It can also lead to decreased quality of care with less time per patient due to fewer people present to do the job (Josephson et al., 2008). The lack of time and stressed employees is unfortunate in the care situation and is likely to increase the incidence of errors. High percentage of sickness absence can also force the manager to use temporary workers, which also is a factor that can decrease the quality of care. The temporary workers are very often unskilled even when covering for a nurse (Bogen & Lien, 2015). The main reason for using unskilled workers seems to be that financial pressure exerted on the manager and nurses from above makes them resistant to using skilled temporary workers. It can also be difficult and stressful for the managers to get nurses to cover for sickness absence (Gautun & Bratt, 2014). Care of the patients given by many different health care workers instead of a small group is likely to give less consistent care where details and information about the health status can be lost. Errors can then be made as a result of the loss of this information. It also has negative consequences for the financial situation, both for the government and the employee receiving sick leave. It is very

expensive to have many citizens receiving sick leave while at the same time paying for people to cover for the sick employees. After one year in long-term sick leave the employee starts to receive less than what they originally make when working. This makes it an unfortunate situation for the individual employee as well as the government (Fevang, 2003; Bogen & Lien, 2015).

4.1 Understanding Sickness

WHO (1946) defines health as … "not only the absence of disease, but a state of complete physical, psychological, and social well-being" (World Health Organization, 2015). This is a broad definition, which includes the whole aspect of health and not only absence of symptoms and hazard of disease. The importance of this definition is that it acknowledges that health is determined and measured across a variety of dimensions, it is not simply physical. Mæland (1999) has three assumptions of health shown in Table 1; he looks at health as absence of disease, as a resource, and as well-being. This is useful in that we can understand sickness as signs and symptoms, the absence of which allow a person to be healthy. Health then is a resource with which one can fight sickness, something one has which gives strength and resistance. How one feels and functions, both in health and sickness, is an indication of one's well-being (Mæland, 1999).

	As absence of disease	**As a resource**	**As well-being**
Condition	To be	To have	To function
Description	Absence of signs of sickness and symptoms	Sturdiness Strength Resistance	Felt well-being Active Good relations
Relation to sickness	Destruction of sickness	Gives resistance against sickness	Can be experienced despite of sickness

Table 1: Mæland (1999), three assumptions of health

When looking at sickness absence it can be helpful to define sickness, illness and disease. Illness is the individual's feeling of being unwell independent of a diagnosis given by a doctor. It is then the individual him/herself that decides if they are ill. The disease or diagnosis is set by the doctor, who can argue if the patient really is sick or just feeling sick. Sickness is the social role; it is given to the individual by the society (Boyd, 2000). To

receive long-term sick leave you need to get the sickness absence certified by a doctor or another health expert. It is however, difficult for the doctor to always be right. Often when tests give unclear results or a diagnosis is unclear, certified sickness absence is then given on the foundation of the patient's experience of his/her own health. Since sickness is a role given to the patient by the society it will get less attention in this paper than illness and disease (Boyd, 2000).

4.2 Defining Sickness Absence

This paper will use both long-term and short-term sickness absence to see if organizational change has an effect on the employees. By doing that it will also look at what the manager can do to reduce sickness absence. Long-term sickness absence is chosen because muscular and mental issues are the main reason for long-term sickness absence in Norway (Arbeidstilsynet, 2015: Rønningen, 2004). These diagnoses are sometimes correlated to the employees' well-being, either at work or home. This might be something the manager can affect by introducing various efforts to prevent these issues, both physically and psychosocially (Fevang, 2003). Long-term sickness absence is certified sickness absence and is assumed to more likely reflect the morbidity of the employees than short-term sickness absence. Long-term sickness absence is also more likely to not be affected by reporting bias and how different individuals are coping with feeling ill as might be problem with short-term sickness absence (Bogen & Lien, 2015; Steers & Rhodes, 1987). Short-term sickness absence is not significantly affected by changes in job demands, level of support at work, or to what extent the employee can decide over own work tasks and situation. This gives reasons to believe that short-term sickness absence does not say much about health and morbidity among the employees (Head et al., 2005). Short-term absence will be used in addition to long-term to cover all aspects of being absent from work. Short-term absence is more associated with dissatisfaction at work; it is less dependent on health status than long-term sickness absence (Marmot, Feeney, Shipley, North & Syme, 1995; Schaufeli, Bakker & Van Rhenen, 2009).

Short-term sickness absence is something that can be affected by the manager and includes factors such as job scope, job level, role stress, work group size, leader style, co-worker relations and opportunities for advancement (Steers & Rhodes, 1987). Job scope up to a certain point is one of the factors that the manager has most opportunity to affect in the

nursing home. By increasing the job scope you give the employee more challenges along with responsibility, which is good for the employees' work attitude. The other factors that the manager can affect are leader style, co-worker relations and opportunities for advancement. Leadership style can be improved if the manager is aware of how he wants to behave in addition to knowing his employees and what is best for them. Opportunities for advancement can be solved with offering more training in new medical areas; this is also good for making employees secure about their ability to perform their job. Co-worker relationships can be affected by introducing measures to improve the work environment; this is also correlated to the employees' work satisfaction (Steers & Rhodes, 1987).

Steers and Rhodes (1987) argue for a distinction between the ability to attend work and actual attendance, each of which is affected by an employee's motivation. One can have a headache and go to work, or one can have a headache and use it as an excuse to not attend work that day. This distinction is important because a good manager might be able to reduce sickness absence by motivating his employees. The motivation is determined by how satisfied the employee is with the work tasks, work environment, and also external and internal forces. Working in the health care sector can be stressful, the days are both physically and mentally straining. Studies show that jobs with a high level of stress in the typical workday are more likely to have a high percentage of sick leave among their employees (Steers & Rhodes, 1987; Fevang, 2003; Schaufeli, et al., 2009). Work situations like this, with lots of stress, can also decrease the employees' motivation to go to work every day and the bar for taking a sick day can therefore be lower than in other jobs. However, if the employees have a feeling of importance of their job and therefore a high internal motivation, they will more likely attend work if they are able to. It is assumed that an employee is more motivated to come to work if he/she is happy with the work environment and likes the work tasks. A good work environment can increase the feeling of social support and create trust at work. This has been indicated to increase motivation to come to work (Rydstedt, Devereux & Sverk, 2007; Schaufeli at al., 2009). Studies show different results regarding improving the employee's work days, such as by making them more exciting, can also decrease sickness absence (Fevang, 2003; Steers & Rhodes, 1987; Marmot et al., 1995).

External forces like financial dependence or rewards can also motivate the employees to attend work. However, health care workers such as nurses are not dependent on working overtime to get paid enough in Norway. More money is therefore not the best motivation to

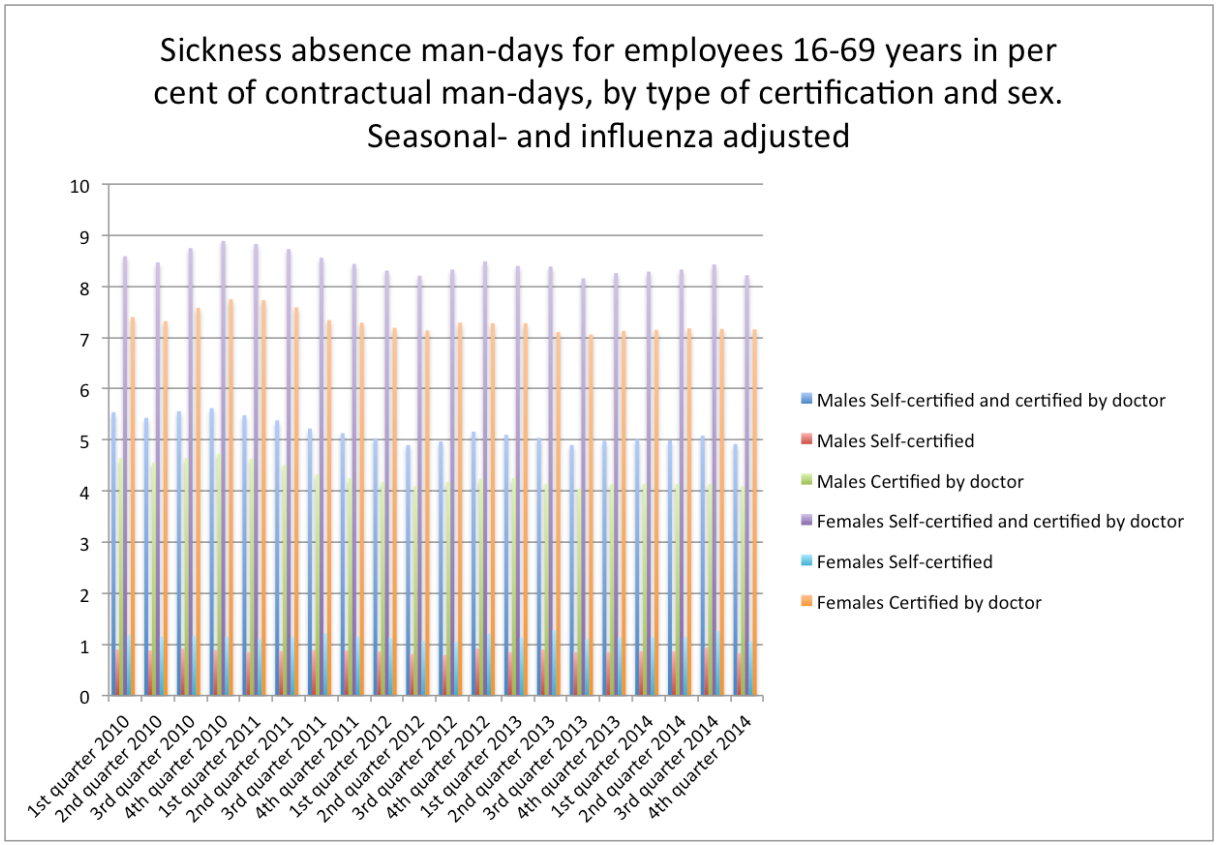
make employees come to work (Steers & Rhodes, 1978; Fevang, 2003). However, high rates of sickness absence often forces health care workers to work overtime or extra shifts. This is either because the manager has no choice but to make someone come or do the job herself, or because healthy employees feel bad not working when they know that their coworkers and patients are struggling. The stress at work for the employees present will likely increase if the non-sick employees do not step in and work extra when there is sickness absence. Overworked and exhausted employees can result from this, which can increase the sickness absence rate in their department (Fevang, 2003). Nurse assistants and assistants in a nursing home often do not get to work fulltime, and this can also be a motivator of taking extra shifts and working overtime. They can be concerned about missing out on opportunities of getting a permanent full time job by saying no to any of the extra days/hours. They can also be dependent on extra hours and worried about not getting enough and then end up overcommitting (Gautun & Bratt, 2014; Fevang, 2003).

4.3 Why Organizational Change Increases Sickness Absence

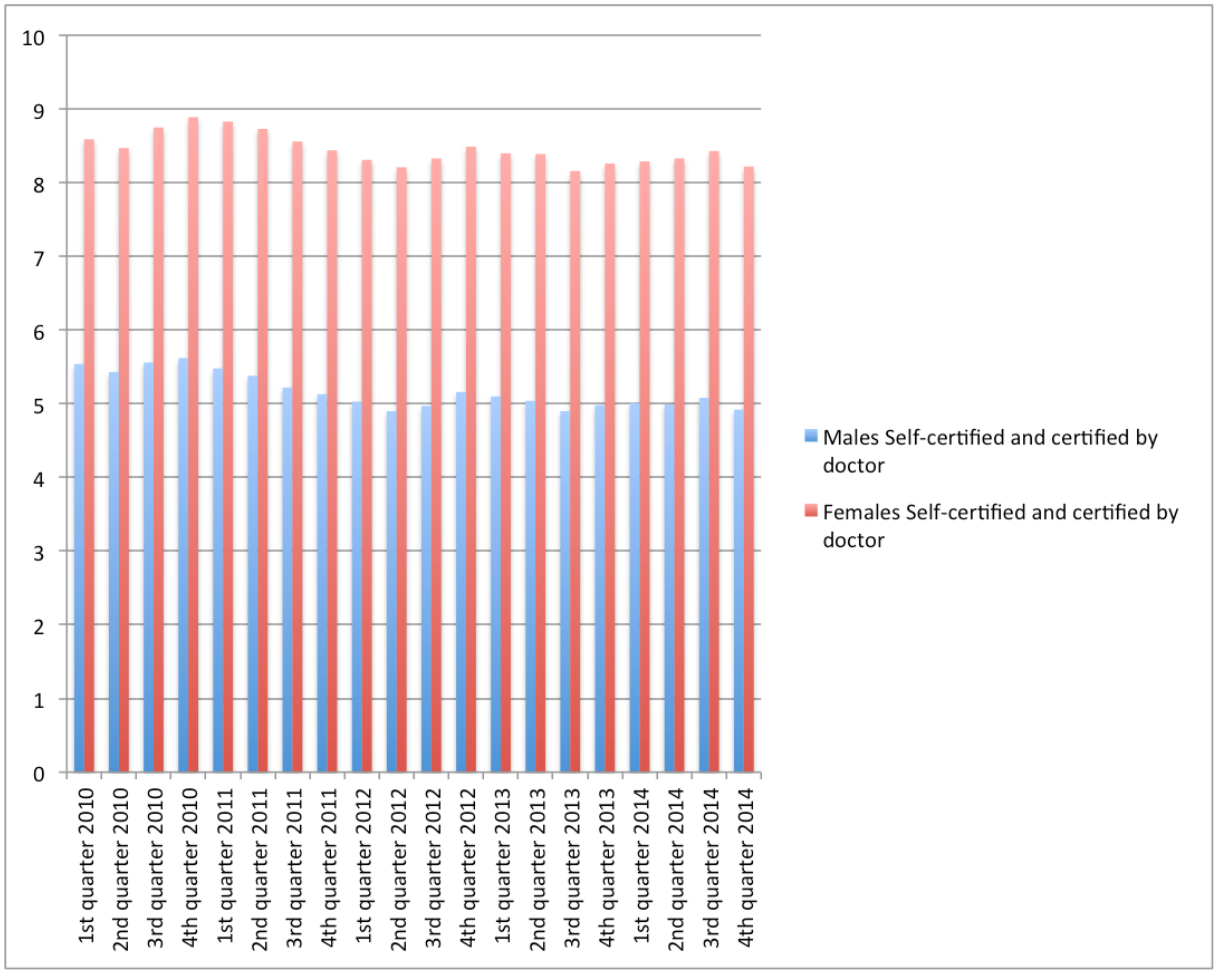
Dua (1994) points out work overload, role ambiguity/conflict in the organization, lack of possible promotion, job insecurity, poor social support at work as well as bad work environment as factors that increase the risk of sickness absence. Poor management can also be a major cause for sickness absence (Fevang, 2003; Michie & Williams, 2003). Restructuring can create this kind of unwanted work environment, while many employees at the same time often feel insecure and stressed about their job situation (Robinson & Griffiths, 2005). This negative stress can lead to dissatisfied employees in the short-term and lower commitment and performance as a long-term consequence. These factors can also lead to lower mental health, lower physical health and lower organizational motivation. Studies have shown negative health consequences such as decreased level of DHEA-S, a stress hormone with anabolic and neuroprotective effects. Decreased level of DHEA-S is typical after a long period with stress and makes the recovery process slower. This might affect the duration of sickness absence (Hansson et al., 2008; Dua, 1994; Vahtera, Kivimäki, Pennti &Theorell, 1999). A Finnish study also shows increased risk of cardiovascular mortality as a consequence of little control over work, which when combined with low social support increases this risk even further. Participants of this study also had a higher rate of taking short-term sickness absence (Vahtera et al., 1999).

Karasek and Theorell (1990) agree that loss of control and unwanted work environment over long-term can have a negative impact on the health of the employees. Their model argues that the employees with the lowest decision latitude will be most negatively affected by change. Research shows that changes in the work demand do not necessarily increase the risk of sickness absence. However, if the changes are adverse and the employees experience them as negative, then the changes will cause increased risk of sickness absence (Rydstedt et al., 2007) The same studies also showed decreased risk of sickness absence when reducing job demands (Head et al., 2005). Restructuring is often experienced as more demanding for the employees. They might also feel a loss of control when going through a change, especially in change processes where there are cut downs, or some employees have to move to other workplaces (Robinson & Griffiths, 2005). Effort and reward are then in imbalance, which can be demotivating for the workers (Rydstedt et al., 2007; Marmot et al., 1995). Burnout, which can cause low energy and cynicism, is the opposite of work engagement, which gives high energy and dedication to the work tasks. A job with a high level of stress is, as mentioned before, more likely to have a high percentage of sickness absence among the employees. Research shows that work overload, high emotional demands and work-home conflicts in conjunction with burnout is associated with higher sickness absence (Schaufeli et al., 2009). The employee is not able to do his/her job anymore because of exhaustion. Increased work demand without increase in work resources as a result of restructuring amplifies this effect. Using the Job Demand-Resources (JD-R) model, Schaufeli, Bakker & Van Rhenen (2009) suggest that sickness absence as a result of inability to do one's job is a result of work strain while more voluntary sickness absence is a result of poor motivation. Strain can come from reduced work resources and/or increased workload, which can lead to distress. Despite the emotional distress from losing resources, the employees often fight to keep them; this can be doubly exhausting and therefore increases the risk of burned out employees (Schaufeli et al., 2009). Head et al. (2005) found that improvement in social support at work decreased the risk of long-term sickness absence.

4.4 Statistics about Sickness Absence in the Norwegian Health Care Sector



Graph 2: The difference between men and women in relation to sickness absence, both certified and noncertified and these two combined (SSB, 2015b).



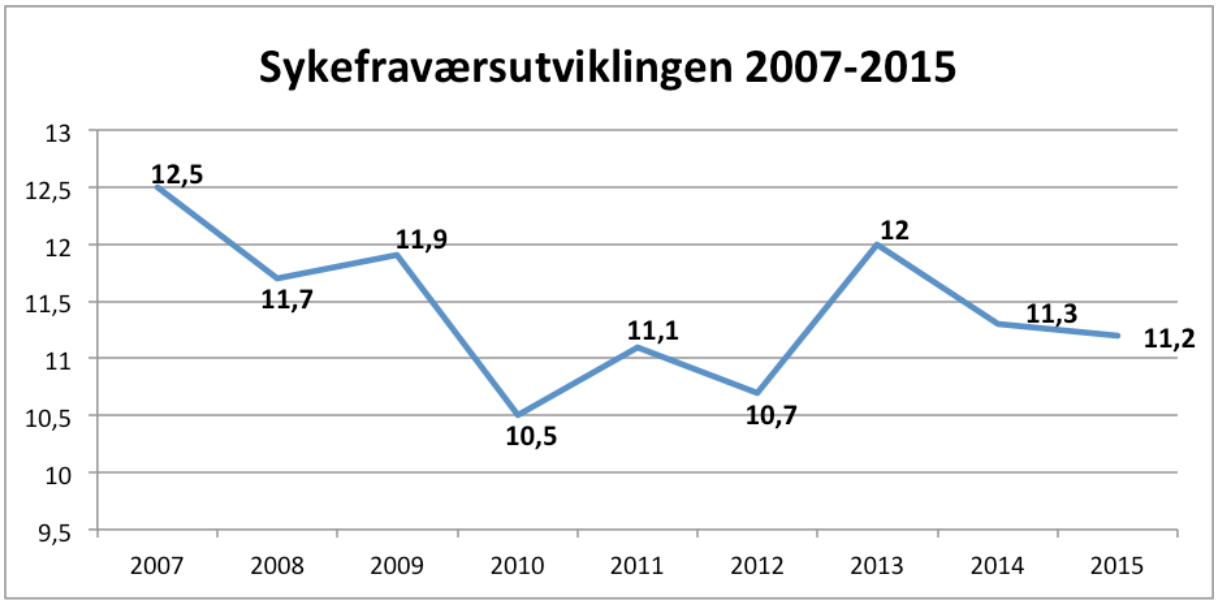
Graph 3: Seasonal- and influenza adjusted sickness absence man-days for employees 16-69 years in percent of contractual man-days, by type of absence and sex (SSB, 2015b).

The healthcare sector has a higher rate of sickness absence than the rest of Norway. As Graph 2 and 3 show, the sickness absence rate has remained stable since 2012, with some small exceptions. The reduction in sickness absence was mainly in the self-certified sickness absence, while the doctor-certified absence remained more or less the same. Sickness absence for both men and women decreased late in the year of 2014. Since 2001, when the agreement on an inclusive labor market was first implemented, the seasonal and influenza-adjusted sickness absence has dropped 11.5 percent (Statistisk sentralbyrå, 2015B).

4.5 Statistics about Sickness Absence in SYE

The sickness absence is higher in the primary health care than specialist health care, with an absence rate of 11.2 compared to approximately 8 percent in the specialist care. The cost of sickness absence is a major concern for the society. By 03.31.2015 the cost of sickness

absence for the Nursing administration was estimated to be at more than 120 million Norwegian kroner. This covered 11.2 percent of sickness absence. Of these 68.7 million kroner is to cover the short-term sickness absence, which was 3.6 percent of the 11.2 percent. The last 7.7 percent is covering the long-term absenteeism and is estimated to cost 51.8 million kroner by the end of 2015 (Arbeidsmiljøutvalget, 2015).



Graph 4: The development in sickness absence between 2007-2015 (Arbeidsmiljøutvalget, 2015)

Graph 4, above, shows the development of sickness absence from 2007-2015. The total number of sick days did increase between 2013-2014. The rate of sickness absence was 12.2 percent in 2014, this number decreased with one percentage in 2015 at the same period, march 31. The sickness absence for the whole year has decreased with 0.1 percentages as the total absence for all 2014 ended up at 11.3. The goal was to get the sickness absence down to 9.5 percent, which is 1.7 lower than what it currently is. The actual cost of sickness absence will be higher than the estimated numbers. Costs of temporary workers, overtime for the employees present, the cost of salary in the transition into receiving disability benefits are some of the costs that are not covered by the first estimation. There are also negative non-financial effects too that can affect the financial situation. Sickness absence can most likely worsen the work environment and increase the strain on the present employees and decrease the quality of the services supplied (Arbeidsmiljøutvalget, 2015). This is a concern both for the cost and the work environment. By increasing the rate of employees present at work we will gain both financially and increase quality in the workplace and services (Arbeidsmiljøutvalget, 2015).

Sickness absence rate by gender pr. 03/31/15

	2011	Pr 06.30.12	Pr 12.31.13	Pr 12.31.14	Pr 03.31.15	Change in percentage points from 2014 to 2015
Women	**11,6**	**11,6**	**12,3**	**12**	**11,9**	**-0,1**
Men	**8,4**	**8,3**	**8,9**	**7,6**	**8**	**+0,4**
Total	**11,1**	**11,1**	**12,0**	**11,3**	**11,2**	**-0,1**

Table 2: Sickness absence rate separated by gender and combined 31.03.2015

Table 2 shows that sickness absence for women has gradually increased in the period 2010-2013, but it went down 0.4 percentage points from year 2013 to year 2015. Sickness absence among men went up 0.4 percentage points from year 2014 to 2015. As you can see from this table, women have a higher absent than men (Arbeidsmiljøutvalget, 2015).

Sickness absence rate divided absence length per 03/31/15

Year	**Total sickness absence** (%)	**Short-term absence** Self reported and doctor certified absence 1-16 days (%)	**Long term absence** Sick leave absence in 17 days or more (%)	**Sick leave more than 56 days** (%)
2010	10,5	3,5	6,9	5
2011	11,1	3,6	7,5	5,4

2012*	10,7	3,5	7,3	5,1
2013**	11,8	3,1	8,7	5,3
2014***	11,3	3,1	8,3	-
2015	11,2	3,6	7,7	-

Table 3: Sickness absence rate by length 31.03.2015

* Pr. 08.30.12

** Pr. 09.30.13

There has been an increase of short-term sickness absence from 3.1 percentages in 2014 to 3.6 percentage in 2015, this is illustrated in table 2. Long-term absence increased from 2010 to 2013, but has gradually went down from year 2013 to year 2015 with a reduction in 0.6 percentage points from 2014 to 2015 (Arbeidsmiljøutvalget, 2015).

4.6 Legal Framework

There are several laws that the manager needs to follow, these laws were drafted with the intention of ensuring a good work environment and reduce sickness absence. Many of these laws cover how the manager and employees together will create an environment that reduces risk of sickness absence. We have extracted parts from the Working Environment Act from 2005 that we think is most relevant for this study. We will put most attention on *Section 2-3. Employees' duty to cooperate,* partly *Section 3-1. Requirements regarding systematic health, environment and safety work and Section 4-2. Requirements regarding arrangement, participation and development***.** These are most relevant for what managers have to consider in a change process and sickness absence. We will not put much effort on explaining the acts, but they should be understood as an important foundation for maneuvering change and sickness absence. We will however, give a short explanation of what is most important in each section (Arbeidsmiljøloven, 2005).

Chapter 2. Duties of employer and employees

The most important section here is that the employees has to cooperate on preparation and implementation of follow-up plans in connection with total or partial absence from work caused by accidents, sickness, fatigue or similar reasons and take part in a dialogue meeting

when summoned by the employer. This means that they have a duty to cooperate with the employer, NAV, doctor and BHT when needed. They have to turn in the doctor certification their next workday. They have to call the manager the three first days of sickness. The fourth day the manager shall call absent employee (Arbeidsmiljøloven, 2005).

Chapter 3. Working environment measures

In this section it is most appropriate to look at the section where they focus on planning and implementation of changes in the undertaking. The manager has to evaluate the working environment under changes and if this meets the requirements in this act. That entails to prepare and introduce measures to reduce the risk of problems. The managers have to prevent and follow up sickness absence related to change. They have to enact control of the working environment and look at risk factors related to the change (Arbeidsmiljøloven, 2005).

Chapter 4. Requirements regarding the working environment

The manager has to look at the physical, mental health and welfare of their employees. This is a big challenge for the manager because they have to judge it separately and collectively. When they plan a change process it is important to have in mind the prevention of injuries and diseases. They have to organize the work arrangements so that the employees are not exposed to internal and external strain in this process. The manager has to look at individual concerns when they facilitate work arrangements. If one has an elderly woman with strain injury, the managers has to take this into consideration while making the shift arrangement and delegating tasks for this women. When there is a restructuring process the employees shall get the appropriate training and they are entitled to good quality of information. The managers have to be included in the decision-making. When they have done all this it will meet the demands from this act (Arbeidsmiljøloven, 2005).

5 Theoretical and Analytical Approach

Transformational leadership, Valley of Despair model, DCS, JD-R, ERI-model, and Maslow's pyramid of needs are the theories and models that are chosen to enlighten the study's question "How does restructuring affect sickness absence and how can managers prevent sickness absence resulting from such changes?" Transformational leadership has been suggested to be a very effective way of leading in several studies (Hater & Bass, 1988). Motivation is also mentioned in several studies as an important factor to make the threshold for taking sick leave higher and to stay healthy, so motivational theories are therefore included. Maslow's hierarchy of needs can be a useful tool to see what motivates the employees. This hierarchy of needs is also mentioned in the transformational leadership approach as something these leaders might be aware of and use when managing their employees (Bass & Riggio, 2005; Hater & Bass, 1988). JD-R model and ERI model explain why people become sick and take sick leave. JD-R, ERI and the DCS-model show why change processes give higher risk for sickness absence (Schaufeli et al., 2009; Rydstedt et al., 2007).

5.1 Leadership Styles

"A transformational leader emphasizes what you can do for the country while the transactional leader, on what the country can do for you" (Bass, 1999, p. 9). Transactional leadership focuses on performance by rewarding good work and correcting those who do less than required. The employees get to do their job without interruption if they are meeting the standard of performance when working under a transactional leadership approach (Burns et al., 2012). This paper will mainly focus on the transformational leadership style. Transformational leaders can differ depending on the person and situation. One can be transformational and directive, transformational and participative, transformational and democratic, or transformational and authoritarian (Bass, 1999). Transformational leadership is the opposite of transactional leadership; it focuses on influencing through vision, motivating through inspiration, stimulating the intellect of subordinates, and individualized considerations (Burns et al., 2012, p. 38).

A manager with a transformational leadership style motivates his employees through giving them challenges and also by coaching and supporting, so they can fully understand and use

their potential. Autonomy combined with challenges is considered important for employee satisfaction in this leadership approach (Bass, 1999; Bass & Riggio, 2005). These leaders might also be more aware of Maslow's Hierarchy of needs and want to help the employees achieve their needs and beyond (Burns et al., 2012). It gives the employees the motivation to do more than what they would have done otherwise. This manager is visible for his employees (Bass & Riggio, 2005; Hater & Bass, 1988; Bass, 1999). The positive attitude and the individual support and consideration from the manager rub off on the employees. Managers with this leader approach are often charismatic, which may help affect the employees' attitudes and values so that they all work more effectively towards the organization's goals. In addition to being charismatic, these managers often build up a high level of trust between manager and employee which makes it easier to get everyone to work towards the same goals (Bass & Riggio, 2005; Burns et al., 2012). They often have great influence and are people that act with high moral standards, are consistent, not afraid of taking a risk, and at the same time counted on to do the right thing (Bass & Riggio, 2005). All the managers with this leadership style usually have some transactional components, as combining the two approaches can make them better at leading (Bass, 1999; Burns et al., 2012).

Health care workers are in general highly specialized and autonomous, which often gives them strong opinions of how things are supposed to be. This group of employees often also has more intrinsic values behind their work and choice of profession other than just money (Buchbinder & Shanks, 2011). They need support and challenges rather than complete guidelines and reward/punishment according to performance (Burns et al., 2012). These are some of the reasons for why transformational leadership might be a good fit for the work environment in the healthcare sector: it focuses on listening and looking at employees individually, not only rewarding them for specific behavior (Burns et al., 2012). Studies show that lack of support from the manager is one of the three most important factors for sickness absence. The other two are long work hours and lack of control over work. Personal support from the leaders in a change process makes the employees feel valued by giving them feedback and encouragement (Michie and Williams, 2003).

Vahtera and his colleagues (1999) support this with their findings of low work control being the stressor that has the most impact on the employees' health. Supportive leadership seems to reduce the health risks among the employees according to their study. The leader should

talk about the change as a group task that everyone has to work together to solve. Collaboration should be done across hierarchy and professions to include everyone and get everyone on board in the change process. Transformational leadership agrees in this by blurring out the lines between the different professions so that everyone looks at each other as colleagues rather than superiors/subordinates (Bass, 1999). This can help give the employees a feeling of control and that they get the support they need in their work days. A possible result from this is a positive work environment with motivated employees and then hopefully less sickness absence. However, research also shows that instrumental support is important as well. This is to make sure that the employees have the necessary resources available and also make sure that the organization is ready for the change, both structurally and with institutional policies (Burns et al., 2012; Vahtera et al., 1999).

Managing Change

Studies of the employees' attitudes towards organizational change support the importance of feeling involved in and have control over your workday. Even though these studies focus on the success of the organization rather than sickness absence, they do mention the same issues and agree much with literature on sickness absence and change. A study by Vakola and Nikolaou (2005) looks at stress at work. They show that poor work relationships and support at work is negative for the employees' attitude towards change; the same was assumed about job insecurity even though it was not included in the study. This study also agrees that these factors are associated with emotional exhaustion. On the other hand, they report that people with high support experience better mental and physical health during stressful events (Vakola & Nikolaou, 2005). These kinds of studies are important now that most organizations never reach the refreezing state before starting a new change process (Schein, 1996). The reaction to change is often compared to the reaction of losing something or someone special to you, and models of grief and loss are used to show this (Vakola & Nikolaou, 2005). The model that will be used in this paper is called the Valley of Despair.

5.2 The Valley of Despair Model

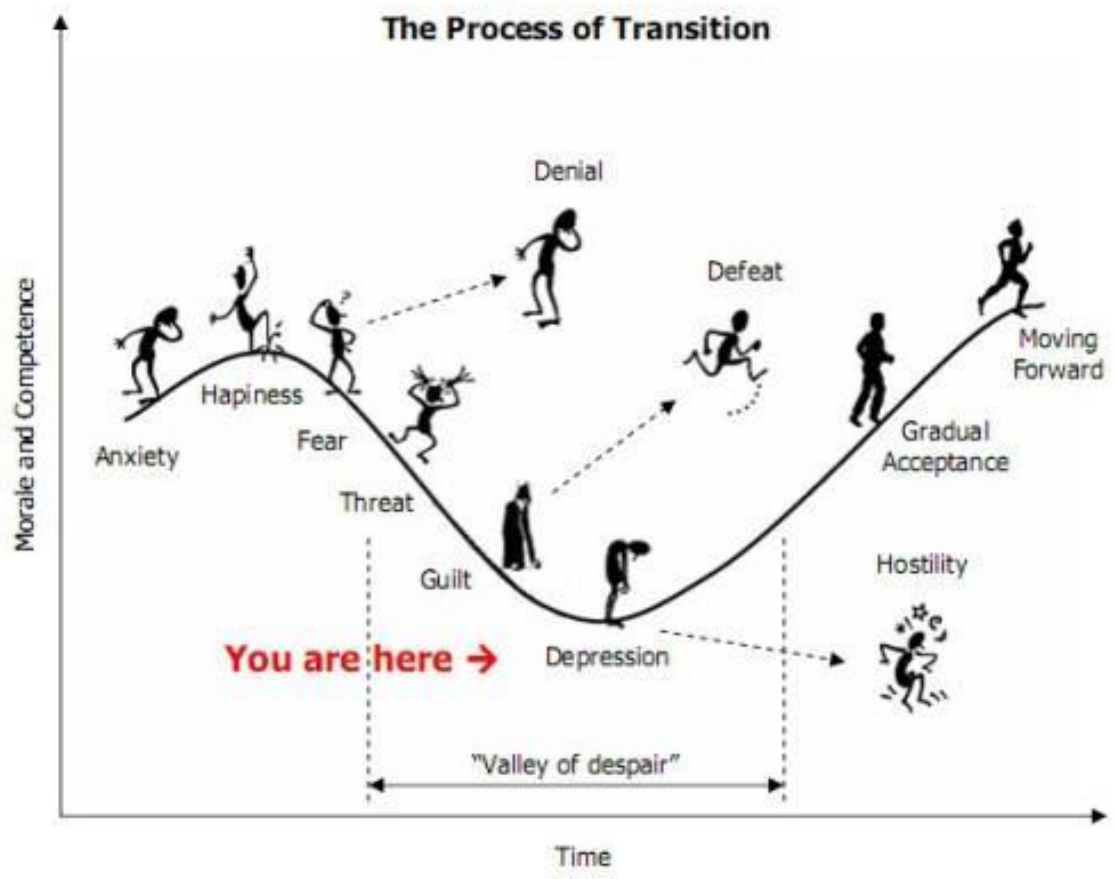


Figure 1: Valley of Despair Model

Figure 1 illustrates how employees often react during change. When the employees are faced with a change, they can experience anxiety or happiness. They can feel fear and some may be in denial. It is unusual, but some may react by making threats followed by feeling guilty. They are then either defeated and move forward or go into depression, where some may get hostile. After a while most accept the change and gradually move on. The model is useful knowledge for the manager because it will help him/her understand the employees in a better way by recognizing the different stages. There is often a resistance to change, which is the cause of the despair. The frustration and hostility that causes the dip into the valley can be a big challenge to the organization and the employees during change. Being in that dip of despair might cause sickness absence. The hypothesis is that by minimizing this dip/resistance you will be able to make the change more successfully and minimize the sickness absence. The employees are often at different stages at all times (Blanchet, 2015).

5.3 ERI, DCS and JD-R models

Theories of organizational change say that all organizations need to change either because of changes in size, management or direction of the organization (Barnett & Carrol, 1995). Organizational change can therefore vary in scale and form of implementation (Robinson & Griffiths, 2005). The process of organizational change and how change actually happens comes with an increased risk of sickness absence for those it is affecting. It is helpful to separate the content from the process when looking at the effect from the changes (Barnett & Carrol, 1995). This is because organizational changes are often inherently stressful regardless of content (Robinson & Griffiths, 2005). The challenge is to understand the process and find the best way to implement it to mitigate these negative effects. ERI, DCS and JD-R models propose solutions to how this can be done.

The psychosocial environment is, according to Siegrist and Marmot (2004), important for the individuals' ability to accomplish their work tasks and to have good self-esteem, and with that have a positive self-experience. A positive experience gives a positive feeling of self-worth and is essential for good health and well-being (Rydstedt et al., 2007). The Demand-Control-Support (DCS) model and the Effort-Reward Imbalance (ERI) model look at the relationship between the psychosocial opportunity structure at work and health outcomes. These two models are suggested to be complementary and have been shown to give stronger results when used together than alone (Rydstedt et al., 2007).

The DCS model looks at the relationship between job demands and job control, and social support has later been added to this relationship. Job control is divided into decision latitude and what skills are required to perform the job. Job demand is the effort the job requires from the employee. Job demand will increase during organizational change when there is often need to work overtime and time-pressure. This in combination with more stressful work conditions and less control will decrease the feeling of mastering one's job tasks, which can lead to decreased self-experience and possibly poor health. Combining low social support with high work demands and low work control will likely increase the risk of poor health outcomes further. To be a supportive manager can be helpful to prevent sickness absence for your employees during a change process that entails little control and higher job demand, according to this model (Rydstedt et al., 2007; Robinson & Griffiths, 2005).

The ERI model looks at the reciprocal relationship between effort and reward at work, specifically at why an imbalance between effort and reward—where the efforts are high and rewards low—will cause negative consequences and stress for employees which might lead to physical and mental health issues. Organizational changes are often experienced as more stressful, and research shows that work-related stress is detrimental for health (Robinson & Griffiths, 2005; Rydstedt et al., 2007). Studies show that employees in situations with an effort-reward imbalance are more prone to physical diseases caused by psychological conditions. The ERI model has for example been used to look at employees' risk of cardiovascular diseases in relation to their psychological well-being (Van Vegchel et al., 2004). Examples of increased efforts can be working under time-pressure and working overtime, while rewards can be money, esteem and job security. Job security will be the most important reward during a change process while time-pressure, overtime and stressful work conditions will be the main efforts. Certain employees are especially vulnerable to the negative consequences of imbalance. These are typically people that overcommit in their job and because of that have a higher need for validation (Rydstedt et al., 2007). This model proposes that this extra strain can be solved with higher reward (Rydstedt et al., 2007).

Job Demand-Resources model (JD-R) looks at the relationship between available resources and job demand. Less available resources combined with increased work demand is related to more dissatisfied employees according to this model. On the other hand, more resources and less work demand are associated with more satisfied and motivated employees. This theory includes factors such as emotional demands and the conflict between work and family, in addition to time pressure and work demands as straining for the individual. Job resources give the employees opportunities to learn and develop through feedback and good relations in the workplace. Autonomy is also important in this model and, along with constructive feedback, cohesiveness, and competence, will help both the employee and the organization to achieve their goals. Job resources reduce job demands—or at least the straining feeling from the demands. Employees that are less satisfied at work have sickness absence more often than satisfied employees that feel commitment to their workplace. Sickness absence can also be used to cope with stress (Schaufeli et al., 2009). Organizational change is often experienced as stress by employees; they can then take sick leave as a means of coping with this extra stress (Robinson & Griffiths, 2005). Sickness absence related to dissatisfaction and little commitment to the workplace seems to be caused by lack of motivation while sickness

absence related to stress seems to be because of excessive strain on the employee (Schaufeli et al., 2009).

5.4 Theories of Motivation

Also appropriate for this study are theories of motivation. Current literature shows that HR practices related to motivation can positively affect an organization's performance (Burns et al., 2012, p. 92). Motivation is a state of mind, either thinking or feeling, that makes individuals work harder and perform better (Steer & Porter (1987) in Burns et al., 2012 p. 92). Several other studies included in this thesis as well as the JD-R-model emphasize motivation as important to make employees want to come to work (Schaufeli et al., 2009; Bass, 1999). The manager should know how to and take action in motivating his/hers employees.

To get more knowledge about how to motivate, the manager should know about the hierarchy of needs to discover what motivates employees. Maslow (1943) divides needs into physiological needs, security needs, belongingness needs, esteem needs, and self-actualization needs, and where the basic needs are the physiological needs. Being aware of these needs might help the manager find the right motivators for the employees. The physiological needs consist of an appropriate paycheck and a work environment that facilitates good work conditions. The security needs consist of the need for a secure job and income. Belongingness needs consist of good work environment where the employees share good relationships. Esteem needs reflect the need for recognition and respect, and are important for the individual's feeling of self-respect and a good self-image. Self-actualization is the last need and at the top of the hierarchy. This is the need for continual growth and personal development and for the use of one's potential (Burns et al., 2012).

The Valley of Despair model is helpful to recognize what the individual employee needs and can therefore make it easier to bring out the potential in the employees in combination with the hierarchy of needs (Blanchet, 2015). It has also been indicated as important that employees see potential for positive effects and benefits of change on a personal level, not just organizationally (Mishra, 2014; Burns et al., 2012). Even though it can be helpful to be aware of the hierarchy of needs, it is important to know that this motivation theory has received critique from several researchers. Some of the critique points out that Maslow says

that everyone needs to fulfill the step below before moving on to the next. There are several examples for people fulfilling their social need before security need. One of the examples mentioned by other researchers is that you can struggle with some security needs, but as long as you struggle together with someone you can make these relationships stronger, for example in a department going through change with a high level of uncertainty among the employees. They can improve the cohesion and work environment by working and struggling together in this situation. He is also criticized for assuming that everyone has a need for self-actualization and that this need is not shaped by the society but within the individual (Neher, 1991).

6 Method

This study is qualitative therefore qualitative study methods have been implemented. A qualitative study makes it possible to go more in depth about the phenomenon we are studying and gives us a better understanding than a quantitative study would have, largely due to the fact that it takes particularity and context into account when examining phenomena. Qualitative research asks how and why, not how much. Qualitative research uses methods that are suitable to describe phenomena in context and, against that background, provide an interpretation that leads to a greater understanding of the phenomena. Qualitative studies stem from a number of perspectives. Qualitative methods are useful for the study of human and social experience, communication, thoughts, expectations, meaning, attitudes, and processes, and are therefore perfect for our purpose (Justesen & Mik-Meyer, 2012).

This type of research is systematic collection, organization, and interpretation of textual material derived from observations, individual or group based interviews, or documents. The aim is to understand things better; in our case we wanted to better understand the relationship between sickness absence and change, to understand more about managers' approach to leadership, and to identify relevant theories (Malterud, 2001). Malterud (2001) says that we do not want to find definite answers in qualitative research, but rather achieve partial understanding and to identify new questions about our research topic. We chose a theory-based analysis style when we discussed our findings. We organized our text according to preexisting theory and logical categories to provide new knowledge of previously known phenomena, like sickness absence. The researcher is an active participant in the development of knowledge in this framework. The researcher wants to shed light upon the subjective experience itself. It is less interesting whether it reflects an objective reality, such that the nature of the restructuring or the physiological symptoms and diagnoses are not the focus. However, how restructuring is felt and experienced as part of leaders' and employees' working life is interesting in this perspective. It is believed that people behave based on what they believe and not just on what is objectively true. "How" questions are suited for analyzing processes and it is therefore suitable to use in our research problem. The findings from a qualitative study are not thought of as facts that are applicable to the population at large, but rather as descriptions, notions, or theories applicable within a specified setting (Malterud, 2001).

6.1 Data Sources

6.1.1 Literature Search

We used different search strategies and search words. Data was obtained from conducting searches in different databases: Google Scholar, Helsebiblioteket, Universitetsbiblioteket and PubMed. We also used books from our curriculum in Management. Further we used public documents from Helsedirektoratet and statistics from Statistisk Sentralbyrå. Some data were also obtained by snowballing and advice from our supervisor. The Norwegian setting was taken into account when needed e.g. when we looked at work environment and statistics. Our search words and key terms were among others: change management, change processes, sickness absence, leaders approach to sickness absence and organizational change.

6.1.2 Semi-Structured Interview

To find an appropriate interview guide we executed a pilot interview with one middle manager. This way we were able to formulate the questions better, get familiar with the interview as a method and ask the respondent about advice. We used semi-structured interviews to be able to go more in depth and have room to deviate some from the guide, but we did state themes and key issues in the guide in advance. We used follow-up questions when the interview object brought in new knowledge about a topic. We used a voice recorder and a notebook when we performed the interviews. We also found it useful to write down words that came up frequently. This helped us when we later coded the interviews. We did most of the interviews together, so that one could be the interviewer and the other could write down follow-up questions and code words. This was important for the quality. However, we could see in the few interviews we did alone that one-on-one interviews might have made the manager more relaxed than when we were two. It was also important to refine our questions along the way and alter our sampling strategy when we needed to. Qualitative research is an iterative process and it is therefore meaningful to evaluate along the way. The interview guide contains 20 questions, with follow-up questions when needed. This guide was a practical tool for us and was used as a checklist. Our strategy when we interviewed was to choose a middle ground. We wanted to appear generally knowledgeable about this topic, but less than the interviewee. In this way they could feel secure and taken seriously (Justesen & Mik-Meyer, 2012).

Selection

Our 16 participants are middle managers in Oslo municipality, from both the public and private sector. Most were from the public sector. They are all females and all of them are or have been middle managers; two of the respondents are currently working as institutional managers, but this is only for a short period, and one interviewee is currently working as a development nurse. We have interviewed managers that are managing departments within special units like dementia departments, neurological department, rehabilitation departments and palliative departments. The rest of the respondents either work at long-term units at nursing homes or short-time units at different helsehus. We have not asked them about age or background, since it is not important for our research problem. When we selected our study sample it was important to acknowledge that answers to questions of experience and meaning also relate to people's social affiliations (culture, religion, socioeconomic group, profession, gender, etc.). Just because you have many participants does not necessarily guarantee transferability. We have to keep in mind that the managers that participate are interested in this subject and may have more competence in this field that the ones who declined. This may affect this study in different ways and we might not see the full picture of the phenomenon being studied (Justesen & Mik-Meyer, 2012).

Sampling Strategies

To answer the research question effectively you include more data from one group or another in a stepwise way when you sample. It should be broad to capture the many facets of a phenomenon (Justesen & Mik-Meyer, 2012; Malterud, 2001). We interviewed middle managers that had been leaders through restructuring. We did not mention how large this restructuring had to be in the form we sent out. The reason for that was that we did not want to exclude anybody who might have important information. We already knew that the primary health care sector had been through and is going through enormous changes. We also knew that the sickness absence is higher in this sector than others, so targeting middle managers in SYE was perfect for answering the research question.

The sampling strategies we used were confirming-disconfirming sampling, snowball sampling and purposeful sampling. Confirming-disconfirming involves looking at individuals that are likely to confirm or challenge our understanding of a phenomenon. Purposeful sampling is sampling where the interviewees were selected because of certain characteristics.

Snowball sampling was when we asked the leaders if they could recommend a colleague for further interviews. We only used this strategy when we did not get enough informants, because it could hurt the quality of the findings. The quality might become poorer when colleagues recommend each other because they could give similar answers, as they might have similar experiences, opinions and preferences. SYE was going through a large organizational change process, which is helsehus and mitt hjem, at the time we conducted the interviews. It was difficult to find middle managers that had the time to participate. On the other hand we had the opportunity to get participants who were eager to tell about the change. Since they were going through the organizational change at the time, the information was valuable because it was fresh in their minds. One of the authors of this thesis also works as a middle manager and it was helpful to use networking skills and recruit colleagues that fit the criteria. We are aware of the difficulty with being impartial and the ethical aspect here (Justesen & Mik-Meyer, 2012).

Our strategy to find participants was to use the manager for the Quality Department in Sykehjemsetaten. She sent out an e-mail to all the institution managers at every nursing home and helsehus in Oslo municipality, both public and private. The institution manager had to forward this mail to the middle managers. There was an e-mail address in this mail that went directly to one of the authors. Using this strategy we got the recommendation and trust from the Quality Department and this would indirectly give us trust among the possible participants. We could also see that this requires the institution managers to forward this e-mail, like a gatekeeper, and that they had to see it as beneficial for their managers. We interviewed 16 participants, one of which was a pilot interview. Sampling was stopped when a broad understanding of the phenomenon was found, called data saturation. Saturation occurs when encounters with new interview participants no longer draw out new themes. This suggests that data analysis has to happen while data is being collected (Justesen & Mik-Meyer, 2012).

6.2 Ethical Aspects

The respondents were informed both orally and written about the aim of the study, the execution of the interview and how we would handle the data. We did this before the interviews through an information letter and again orally right before the interview (appendix I). Many of the respondents seemed to be familiar with these kinds of projects. We had to get

an informed written consent before the interview and it was important that the participant knew that she could withdraw from the study at any time. Given the importance of informed consent as discussed by Dalen (2004), consent forms were used to inform our interviewees about important aspects of the study beforehand and then stored separately from the interview material to secure confidentiality. This guarantee of anonymity is especially essential in qualitative research interviews (Kvale, 1996). We saved audio recordings with three letters keys that only could be understood by us. The notebook was stored separately from the audio. The interview guide also gave the ethical committees an overview of our research. We sent in the guide to "Norsk Samfunnsvitenskapelig Datatjeneste" (NSD) and got it approved. The collected data was kept separate from any information that could identify the respondents. The recorded interviews were stored on a separate voice recorder that was never connected to a computer with an active internet access. The recordings were deleted immediately after being transcribed and were never at any time available for anyone but the researchers.

6.3 Quality Criteria

Different quality criteria are important and we want to highlight respectively, validity, triangulation, coherence, consistency, transparency and reflexivity. The meaning of the concept validity depends on which research tradition you apply it to. We use this concept when we do interviews and in this context "validity is about the extent to which the conceptual definition of the phenomena analyzed is adequate for what needs to be described" (Justesen & Mik-Meyer, 2012, p. 39). In other words, we ask: are the findings shedding light on the research question and if so, to what extent? It should be noted that scholars are debating whether validity is applicable in qualitative research. Adopting more than one angle on a phenomenon is called triangulation. Different and many observations can enrich the description of a phenomenon. For a study to be coherent, the research question, the theoretical choices and the method have to correspond. Consistency is related to coherency. It is almost the same, but it is about applying things in a consistent manner throughout the project and it requires precision and the ability to be reproduced. For a study to be transparent it is important that you make the methodological and theoretical choices explicit and justified in the text: assumptions and choices along the way have to be shown. You also have the matter of reflexivity with the recognition of the influence a researcher brings to the research process. Reflexivity is the study of oneself as a researcher and the research relationship

(Justesen & Mik-Meyer, 2012, p. 39). We will write more about reflexivity along with validity in Methodological Considerations.

7 Findings

We had numerous findings from our interviews, from which we have decided to focus on three main topics, which we will divide into three main chapters, respectively: change, leader qualities, and cause of increased sickness absence in a change process. Further subchapter divisions will be made.

7.1 The Change Process

We asked the managers to provide some background on the change their departments went through. Many of the respondents were affected by the large merger of helsehus and mitt hjem. “The change was to create a long-term home, a short-term nursing home (helsehus) and a merged palliation department.” Other changes they reported were the merger of palliative departments and privatization of a nursing home. The managers also reported small changes like facility changes, system changes, change of management, change of work arrangements and new work tasks. One manager said that her department consisted of two wings, respectively south and north. The employees worked separately at either south wing or north wing. “The change is to get staff to walk across the wings.” Another manager told us about a change in use of systems, specifically the implementation of Gat [a comprehensive management tool, which helps the manager with administrative work processes involving staff and their activities. In addition, employees receive an overview over their working conditions and the opportunity to influence their work] (Gatsoft, 2015). “I did this on the nursing home I was at earlier and at the nursing home I'm at now. I’ve terminated paper and now it's just the electronic Gat system that applies.”

7.1.1 Effects of Changes

One question from our interview guide asked how big the effects of the change process were on the employees. The answer we got was that the effects vary depending on what kind of personalities your employees have, but that they recognized fear, resistance, and excitement to name a few reactions. Increased level of conflict was reported as one of the effects from the changes. This was especially in changes involving a merger between two or more departments where the different cultures mixed poorly. Some of the managers also reported

that they felt that the job they had done as a manager previous to the change was less important and they recognized the same feeling among their employees when there was a big change, which was frustrating and disappointing for all of them. This feeling seemed to be dependent on the level of ownership they felt over their work and the age of employees. Most of the managers reported a difference in older and younger employees, where the older employees seemed to struggle more with changes. Younger employees were generally more positive from what our participants experienced. All the managers said they saw reactions from the change in the employees. One of them explained it by saying: "from a scale from 1-10, I would say 10," regarding how much the change affected her employees. Another manager phrased how the change process affected her employees and what she did with it as:

> It had a large effect on the employees; we tried to mitigate it as much as possible because when there is a change, people get the feeling of everything changing. Especially when you move to a new workplace. I tried to make them think of what is not changing, because some of them got the feeling of a catastrophe happening.

Changes that affected the work arrangements had large effects on the employees and these changes also created conflict in the workplace in several cases. A few managers said that they were not able to affect the changes because it was decided from above, but it nevertheless resulted in some resistant and upset employees. A big proportion of the respondents got questions about the work arrangements, even when this was not the primary change. They said that many of their employees were concerned about getting a new shift arrangement. They did not want that to change because work arrangements affect their private life and routines at home. A lot of disturbance during the process was something all the managers reported. Most of them did not feel like they got enough time for everything they needed to do, as too much time was needed to gather information, manage the change, and calm down employees. One manager said it felt like she never had enough time anymore:

> I do not know what it means to be up-to date on work anymore. I have not known that the last year. It is a big change for me too, as the night service at the house is very important and it is a time with fewer people at work. Things happen in the night, it makes it important to have people at work that I know are doing a good job. This gives me increased workload as well.

Increased rate of sickness absence was reported by a big proportion of the managers as an effect of the change. Some reported the rate of absence to be highest at the beginning but most of the managers reported highest rates during and after the change. The managers with highest rates of absence in the beginning said they thought the employees got sick before the change because they were overwhelmed and not able to handle it. The managers with most absence during and after said they thought their employees got sick because they got exhausted or simply did not like the change after they saw how it turned out. They also reported problems related to the increased sickness absence: they got more to do and had to prioritize change-related tasks. In some cases it also gave the employees more to do, because they did not or could not always get more people to work extra.

7.1.2 Reactions from Change (The Valley of Despair Model)

The managers reported and observed several feelings from the employees in their change process. We divided the observations into three groups, respectively before, during and after the change. A pattern was that the managers observed the same feelings in all three stages. All of the managers mentioned emotions from the model of "Valley of Despair." Several leaders also mentioned the name of the model and could name every stage of it. They reported negative feelings like uncertainty, fear, shock, disbelief, denial and resistance before the changes were executed.

> I suggested that someone could switch departments. That was totally out of the question, it turned into a crisis. They cried and threatened with sickness absence. A few did go out in sick leave. We then found out that forcing people to move is not a good idea unless it is absolutely necessary.

A few managers reported positive feelings from their employees like excitement, enthusiasm, happiness and motivation in the first stage. During the change process several of the managers reported feelings like neglect, anxiety, defeat, fear, hostility and frustration. A pattern was that the managers saw the need for more information, their employees wanted to know more about the change and what was going to happen. They needed information to reduce the negative feelings and several managers said that: "Information is the main aspect in a change process."

Uncertainty about the future seemed to be the cause of a lot of stress. Two managers reported only one positive feeling during the change process. Lastly the managers told us about observed feelings after the change. Negative feelings were consistent here with feelings like tiredness, stress, frustration, negativity and disappointment. “Some employees say they cannot sleep and that they can not bear the change.” We should also mention that there are more observed positive feelings in this stage than in the other two stages. They reported positive, happy, excited and motivated employees. Some employees also saw the change as a positive challenge.

Some of the managers reported differences in feelings between their groups of employees. They said that the nurses got less concerned than the nursing assistants and assistants. The main reason for this was that it is easier for nurses to get a new job if that become necessary, and a few of the managers already saw that some of their nurses quit their jobs because they did not like the change. One manager also thought it could have something to do with the level of education, and they guessed that higher education gives you a better foundation to handle uncertain events. Other managers did not see this difference; they thought that it was person dependent.

7.2 Leader Qualities

The respondents reported on leader qualities that we can divide into institutional qualities and instrumental qualities. There were fewer in the latter category. Words and qualities like nice, honest, knowledgeable, open, cooperative, respectful, trustworthy, visible and maternal fit in the institutional group and qualities like strategical, active and efficient fit more with the instrumental approach. Some of them also described themselves as being a conductor, being completely honest and going straight to the case. A pattern is that the managers gave answers that correspond to a transformational leadership style where they can be directive or participants, authoritative or democratic. This will depend on the situation. A few managers gave some answers that correspond to being a little more authoritarian in the way of leading their employees, while the biggest proportion said that they were democratic. Most of them also said they were participative rather than directive during the change.

The majority of the managers emphasized how important it is to see and lift their employees. A big proportion of the managers agreed in the fact that everyone needs to be heard and feel

like they are a part of the team for the work environment to be good. The managers also pointed out that this was important for employees to have good attitudes towards work and to make them want to come to work. One also said how easy it was to be a little too kind when the maternal instinct kicked in. This was especially mentioned in relation to letting people take sick leave because they were feeling sick and had a difficult time at work and home. To be supportive was also a quality several of the managers felt was important because of all the emotions and uncertainty involved in a change process. Other managers agreed and told that they are caring and generous, and that they wanted to be a good role model. One manager described herself as follows:

> I am very upfront, but I think that I am able to combine generosity and care while I stipulate demands. I do not hesitate bringing things up, this can be uncomfortable for the person concerned, but I think it is better afterwards.

A few also mentioned how it was important to make demands from their employees; it is after all their job and they have a duty to perform that job. Some of these managers could be tough, they were not afraid of confrontation when needed. They were what they called soft authoritarian with some of their employees. Some of them said they thought they were able to combine the demanding side with a more soft, caring and supportive side.

> I am clear and precise, but not aggressive and precise.

Many of the managers also emphasized the importance of being clear and consistent with the information and action during the change. To be fair, honest and respectful were also mentioned as important qualities. More practical qualities like problem-solving, information gathering and risk analysis were also valued among several of the managers.

7.2.1 Leader Strategies towards Change

We asked the managers what they believed was the best leader approach in a change process and we got several different answers. We want to divide this into two groups, respectively indirect strategies and direct strategies.

Indirect strategies they thought would be efficient in a change process were short talks with the employees and a good dialogue, focusing on good work environment and making a good atmosphere, throwing the ball at the employees, good information flow, following the change through, giving feedback to the employees, building them up and being a team player. A few managers said that they had problems with not enough time to take care of the employees' well-being while at the same time as taking care of new routines and all the administrative work during the change process. They saw the importance of giving good feedback and building up their employees. They wanted to be more visible out in the department so they could be a part of the team and pay attention to how their employees were doing. Many of the managers wanted room for talks and wanted co-determination from their employees. All the managers said good and adequate information was most important for a successful change process. Many managers empathized on using their experience from the past and wanted to prepare their employees on what feelings or happenings that could come from such a process. One manager said that even though she could not predict exactly, she meant that is was important to make them ready for a change and to help seeing the positives about it. She explained how she wanted to prepare her employees:

> You can say something beforehand, so that they can think a little about how they want to meet their new coworkers. You surely have had some coworkers before that you did not have good chemistry with, but it usually works out ok. Why does it turn into a complete crash when you meet someone from another side? There are a lot of emotions here, so I think it is important to be prepared for that.

Direct strategies were conducting risk analyses, taking measurements, having knowledge about change processes and change management, open door policy, using safety representatives and elected representatives actively and gathering information. Some managers have talked about performing risk analysis before the change. That way they felt more prepared and had actions ready if any problems occurred. Measurements to follow the success of the change process have been used with good results. One manager made an evaluation scheme after the change process; a few other managers had conversations after the change where they asked for feedback. A few managers mentioned how important good planning is before you tell your employees about the change. They said that it is easier to be steady and show your employees the way in a chaotic change process when you are well prepared.

> I planned a lot before I told my employees about the change. That is also a way to get people onboard. It is not easy to make things up yourself when everything is planned, it is a good strategy. I pretend that it is a democracy, but it really is a coup.

Motivational Strategies

We asked the managers how they motivated their employees during change. The first thing many of them said was that they needed to be positive in the initial dissemination of information and to have a positive approach to the change. The next all of them agreed on was to make sure of that the information was as good, clear and adequate as possible. They said that without good information the employees had many questions and the level of uncertainty increased, which made motivating them challenging. Good communication was also a strategy that came up frequently during the interviews. Strategies that the managers used to make sure that they had good communication in their departments were having an open door policy, talking together, having more meetings both one and one and with everyone at the same time, openness at work, and walking around in department to be visible. Most of the managers were concerned with employees hesitating to talk. They meant that it is important to get out the frustration and make sure there are no misunderstandings. One said that is has been important to let the employees take their time to wrap around the changes and also to be open and understanding. The managers also tried to fuel the positive so it could spread around in the group. They meant that it can under some circumstances be more effective to be motivated by your coworkers than your manager. As one manager said:

> I always try to say: Think about what you want to use your energy on. Are you going to use it on everything that is bad and hopeless? Or are you going to look ahead and find solutions instead of snuggle up to the negativity?

The next thing that most of the managers said was that good teamwork was necessary in a change process. They had many strategies on how to improve the teamwork. A few examples are the importance of supporting each other, the manager going in and doing manual labor and work, doing things together as a team at work and having social gatherings during free time. One manager said “we are going to see it through together” when she talked about teamwork. To let the employees be creative and give them time to come around for the

change was also mentioned as necessary in addition to having the necessary needs fulfilled. The managers emphasized at the same time making the employees responsible for a good work environment and increasing the awareness of sickness absence and the consequences of it.

> I threw the ball back to the employees and asked them what they could contribute with.

Another strategy many of the managers used was to focus on the positive, like some managers got to have more employees at work at all their shifts. How they could develop their professional level with practical medical courses and get a new and exciting group of patients was also focused on to make the change more exciting. For some the change was a challenge and helping to see it as an opportunity for professional development instead of just fear for new work tasks was helpful. Some got shorter travel to work and some got more people at every shift, to mention a few advantages. A few managers focused on how the change would benefit the patients by getting increased competence in the department, better routines and more people at work. One manager explained how she used non-physical rewards to motivate her employees:

> We do not have a physical reward to give them, but we do have the dialog, sharing of competence and the ability to help each other. We used medical training courses to increase the professional level, this made the job more exciting. It also gave the employees more confidence in their ability to perform a good job.

Some mentioned LØFT-samlinger as a strategy. LØFT is an abbreviation for solution-focused approach, which is an alternative way to solve problems. You identify and characterize what is working in the organization. The main purpose is to raise awareness of what is working instead of what is not working (LØFT instituttet, 2015). Another manager used motivation umbrellas for the employees to hold on to. She explained these umbrellas as something tangible they could work toward. She thought that as long as the manager had control, the employees would be more relaxed and not worried and nervous. Carrot and stick was mentioned as a strategy by one manager. She said that they have a job and that they will see the consequences both when they do what is expected from them and when they do not. Yet another manager made a big poster where everyone wrote down all the things that would

not change in the change process to show that most of their lives would remain the same. She said this helped to comfort her employees by minimizing the feeling of change and chaos.

7.3 Cause of Increased Sickness Absence in a Change Process

We requested the managers to think about the cause of increased absence in a change process. They were very consistent on "uncertainty" as the main factor for employees being sick. This was related to employees feeling unsafe at work, increased workload, new surroundings and environment. This combined with problems in the private life was especially mentioned as being a cause of sickness absence. Many of the managers pointed out that you can handle a rough time at one place, but not two places at one time. One manager described what the feeling of uncertainty during a change process does like this:

> Uncertainty, we know that people are scared of changes before we have tried it out. It does something with us, I know that after being a part of many change processes earlier too. It is the part of not knowing what is going to happen that makes us insecure and is cause of sickness absence.

Some of the managers believed that feelings like being overrun and being ignored also could be a cause to report in sick. If the employees disagreed with the change and felt forced, the managers replied that this could increase sickness among their employees. They also told about employees that disagreed with the change who had reported in sick and that lack of trust could increase the possibility to get sick. Further they told about employees who had gotten a worsened workday and did not feel that they had gotten enough information. Lastly they thought that stress, dissatisfaction, force, resignation, anger, fear and exhaustion could contribute to the burden of disease.

One of the most important and consistent answers was the importance of good quality information. Many said that they did not have any information to tell their employees and that they struggled with this. They said that their employees showed a lot of emotions and that many of them were stressed, angry, exhausted and dissatisfied because of this. The

managers were afraid that these emotions could lead to absence. Many of the leaders were afraid that the lack of trust in them and the organization also could increase absence.

7.3.1 Strategies towards Sickness Absence

The managers had many strategies toward decreasing the rate of sickness absence. Some strategies were quite formal while others were informal, with a good deal of overlap and blurring between these two categories. More formal strategies included "tett på," a project in cooperation with IA combined with dialogs with NAV. The managers used BHT strategically and required an assessment of the function from the doctor to see if it was possible to facilitate for the sick employee to make she or he able to work. Calls, SMS and sending flowers were used to remind the absent employee that their manager and coworkers are thinking of them. Invitations for lunch at the workplace were also used to make the employee less worried about coming back. The manager thought it would be easier to get back to work if they did not feel left out and sometimes were present. The manager has to use the HR-system when following up employees at sick leave. One manager described it as a tool that creates more unnecessary bureaucracy instead of being helpful, all to satisfy some directives she thought were completely without purpose, that she was legally bounded to do. For short-term absence some managers showed the employee his or her pattern of absence. They felt that it was helpful to reduce the sickness absence by showing the employee the pattern of absence and maybe make them a little ashamed over how it looked. One manager told us about her experience with this method:

> Tett på is giving us a new tool. We get more documentation so we can show the employee his or her pattern of absence. I have experience with this, they often react with: 'is that how it looks? Uh oh...' Then they start to be more aware of the sickness absence and I put some responsibility over at them for showing up at work.

A pattern from the answers was that they wanted to change the focus when looking at sickness absence and it was assumed that focus on the employees who were present could reduce the risk of sickness absence. By doing this they could spend more time calming down worried employees and also motivate their employees to follow the change through. This shift in focus at sickness absence was emphasized by many respondents, but they told that they were concerned with not having enough time to follow this trend through. The reason for not having enough time is that they still had to do the formalities around sickness absence.

Other strategies that all the managers agreed on were to make everyone aware of the trouble with sickness absence and also having graded sickness absence in some cases. Many also emphasized how important it is to see the employees and be present for the patients and colleagues. They said that by doing that they also show that they care, which made it easier to have good communication and work environment as well as increasing job satisfaction among the employees.

Early dialogues, conversations and follow-up was used for long-term sickness absence combined with trying to facilitate so they could come back to work faster. Some managers said that sometimes these efforts worked, other times the reason for long-term sickness absence makes it impossible to affect. One manager said she always asked for the sickness note from the doctor to be delivered in person instead of it being sent in the mail. This way they could have a coffee and talk a little at the same time. Another pointed out flexibility with shifts as something that can help reduce sickness absence, as this is something that is a concern for many employees.

A few managers said they could make a "scare culture" to keep the sickness absence low. If you make a culture where it is not ok to call in sick, less people will do it was the idea. When an employee has not followed the guidelines for taking sick leave, the manager can make an example by having a hard talk to this employee. This employee then returns to his colleagues and tells about it. By doing this the manager scares other employees from doing the same thing. One manager mentioned that she knew managers that used this strategy successfully, but she thought that a manager has to have certain characteristics to follow this through. Another strategy to scare the employees is to take them in and show them their sickness absence pattern and let them explain why they are always sick on Saturdays. Many of the managers told that this was a very efficient and cost saving/time saving strategy to use.

Many of them mentioned the legal framework that they need to follow when following up employees in sick leave and creating a work environment that can prevent sickness absence as far as possible. Managers are required to follow rules and procedures. They will be indirectly affected by laws no matter what they do as leaders. The legal framework is the foundation for what strategies the managers can and cannot do.

8 Discussion

Here is a summary with the main findings from our study:

The Valley of Despair

All the managers recognized emotions their employees had that are represented in the Valley of Despair model. They used this to approach the employees in the change process with the purpose to prevent sickness absence. The knowledge the leaders had about the Valley of Despair model was comprehensive. Many leaders surprised us by saying the name of the model and all stages in it.

Management Approach

A pattern is that a large proportion of the managers gave answers that correspond to a transformational leadership style. Some gave answers that showed a side that was more transactional as well. The latter had a more strict way of leading with use of reward and punishment. This could lead to a "scare culture", which they thought could prevent sickness absence. The managers that took on a transformational approach had a high level of consideration for individuals. They focused more on trust, support and being a team player. They did not mention more courses and education for the employees as a mean to increase motivation amongst employees to the degree we thought they would. They rather focused on getting a better work environment by taking different initiatives such as providing adequate information. The transformational managers displayed visionary and creative qualities which helped them to inspire the employees to follow through with the change and to prevent sickness absence.

From Absence to Presence

The leaders with a transformational approach had a high level of individual consideration for their employees. They wanted to change the focus when looking at sickness absence and it was assumed that focus on the employees who were present could reduce the risk of sickness absence. This leads us to what we want to call "from absence to presence," which almost every leader emphasized. This is a new and upcoming trend in SYE and the managers were influenced by this. The problem was that they still had to deal with the formalities around sickness absence and they therefore lacked time to carry out this new trend. Formal and informal strategies were used to attempt to prevent sickness absence, most important here is

focusing on having a good work environment (both formal and informal), following up the absent employee, and the importance of information and building trust.

8.1 Discussion of Research Problem

The purpose of this paper is to see how restructuring affects sickness absence and how managers approach the sickness absence which results from such changes. To discuss this research question we want to divide the discussion into three sections, first "experienced change," where we address how and why the change process is affecting the sickness absence. The second and third sections are, respectively, "managers' approach to change" and "from absence to presence," which will address the managers' approach to sickness absence and discuss transformational versus transactional management. The main findings from this study are illustrated in Figure 2 below. It shows the different strategies the managers used to approach sickness absence and change. It also suggests a relationship between the experience of change and the approaches that they chose. Lastly it illustrates that we were able to divide the strategies in two categories: transactional and transformational. The leadership approach each manager chose affected the choice of strategies as well as the experience of change.

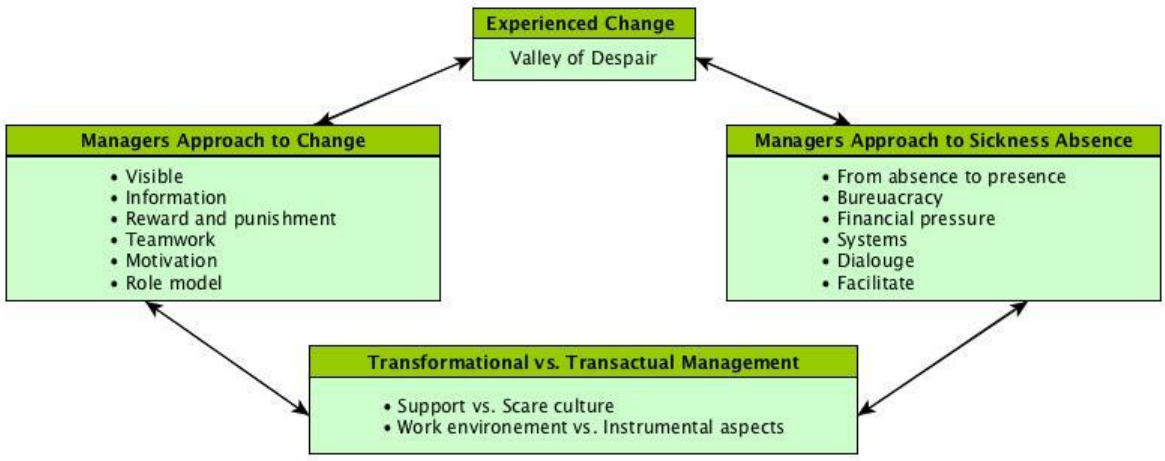


Figure 2: Main Findings

Experienced Change

The primary health care sector has a high rate of sickness absence, this is challenging for the managers, the employees, the patients and the society. The sickness absence rate in the

healthcare sector is higher than average rates of absence in other sectors. This sector also has a high rate of organizational change. When the Coordination Reform was implemented in 2012 the primary health care in Norway had to restructure their health care services to meet the new demands (Kjekshus, 2014 A; Helsedirektoratet, 2015; Oslo Kommune, 2015). This is why we want to look at how change is experienced and methods that the managers can use to make the change experience better for the employees, and for themselves. This can hopefully mitigate the sickness absence and make the change more successful.

Three Stages of Change

The middle managers participating in this study had been through many different changes. By using Lewin's three stages of changes, unfreezing, moving and refreezing, we can determine where in the change process the sickness absence was highest (Iles & Sutherland, 2001). This is in accordance with previous studies as well (Kjekshus, 2014a; Hansson et al., 2008; Josephson et al., 2008; Bourbonnais et al., 2005). Only a few reported trouble with the unfreezing stage. There did occur a little resistance in many of the departments, however it seemed like most of the managers got all the employees on board with enough information and good reasoning for why the change needed to happen. A bigger proportion of our participants had trouble with sickness absence and uncertainty in the moving stage of the change process. The managers met more resistance from the employees in this stage, especially when there was not more or adequate information to give. The last stage, refreezing, where the new change is becoming the routine, gave many of the participants problems as well. Especially the changes where they merged two or more departments resulted in conflict between the different cultures that suddenly were supposed to work together. The different departments might have done the same job, but performed it differently; this was reported to cause an issue. Some of the people that started out positive in the process turned around and became negative. This last stage gave increased sickness absence rate for almost all the participants.

A pattern was that the managers said that changes had a large effect on the employees and created a feeling of fear and uncertainty. The employees felt that the work they had done did not matter anymore. This was recognized by the managers in the employees in the context of having to change the way of working after many years. The DCS-model explains this feeling by saying that it is straining for people to lose the feeling of good self-experience, which can happen when they feel like what they have done before loses its value (Rydstedt et al., 2007).

All of the managers felt that the information flow was poor in all of the change processes. Even in the changes that started out with good information ended up with inadequate information after a little while. This has been a challenge, both for the employer and employees. One manager said she felt that the change was just given to her, without any information on how to perform it. She felt less control over work during the change, a feeling that was amplified because the change felt forced. That she, and most of the other managers, got twice as much work to do during the change process did not make it easier to maintain control. This is illustrated by the ERI-model that says increased demand at work combined with less control is detrimental for the feeling of mastering one's work tasks (Rydstedt et al., 2007; Robinson & Griffiths, 2005). It is also difficult to calm down worried and scared employees when you do not have any specific and good information to show them. One of the participants said that all you can do as a manager is to say "it`s going to be ok."

Valley of Despair

We wanted to know if the managers that knew about the Valley of Despair are better prepared for change. All of the managers recognized the emotions from the Valley of Despair model. Valley of Despair is explains a sequence of emotions by showing the different stages that employees went through, as explained in chapter 5 on Theory (Blanchet, 2015). What was most interesting was that several managers knew the name of the model and could recognize the different stages. They are all educated nurses and they learn about similar models at nursing school. It can be an advantage to know the meaning and to use this model in a change process and especially when you try to reduce sickness absence. If the manager can recognize the feelings and use them to approach the employees they can be better suited to handle critical situations. As they are nurses they are accustomed to meeting people in vulnerable situations. As a nurse you have to answer hard questions, but you also have to ask the appropriate and difficult questions. We experienced that the managers who had comprehensive knowledge about this model thought that these talks and situations were less difficult to handle. All the managers observed uncertainty and the feeling of loss of control as well as fear and suspiciousness. These feelings are common during loss, which is what a change process often feels like (Blanchet, 2015). Some of them also experienced that their employees were motivated and excited for the change, however this feeling often did not last through the whole process. It differed between the employees. Some were positive and motivated in the beginning and maybe disappointed when they saw how it was going to be.

Others were only positive at the end when most of the uncertainty was over and things had stabilized.

Many of the managers mentioned that they thought it was person dependent how the employee reacted, which can be explained by the Salutogenese theory. This theory shows how people with a large sense of coherence handle unexpected or uncertain happenings, such as during a change process better than people with a low sense of coherence. These people tend to have a better attitudes and coping skills, and tend to find more meaning in what they do (Antonovsky, 1987). This theory explains why some people react much stronger to certain events than others. As one manager said, "some people will always be worried, no matter what." She further talked about how important it is to focus on the attitude among her employees and that she tried to make everyone positive about the change. A few managers suggested that uncertified sickness absence was sometimes taken because of the need to get time to cope with stress and tiredness. This is in accordance with both the ERI and DCS-models that explain how control over one's own work situation affects the individual's health and well-being, with more control leading to better health and less control causing worse health (Rydstedt et al., 2007).

Common for all of the participants was that they focused on how to handle all of these feelings. Blanchet (2015) says that recognizing the emotions makes it possible to find different strategies for each employee to get them on board to be motivated for the change. As we said earlier the managers wanted to spend time on the employees who were present and positive about the change. They also mentioned that it was a good strategy to use the employee who was most positive about the change as a role model. However, they lacked the time and tended to spend more time talking to and calming down worried and scared employees than fueling up positive employees. The leaders felt that they were piling up in paperwork and daily routines and found it difficult not to have time to have longer talks with their employees. We believe that the managers who took a more transformational approach here and were more visible for their employees could have better chances for success. Studies of transformational leadership agree with our assumption (Bass & Riggio, 2005). The managers that did this were also able to catch up the employees easier than the other managers. This is an advantage when using the Valley of Despair model to prevent sickness absence. The positive attitude and the individual support and consideration from the manager rub off on the employees, but this is dependent on having time to actually follow this

through. We had a feeling that many of them wanted and favored this approach, but they just could not find the time or right approach to do it.

Managers' Approach to Change

Transformational vs. Transactional Management

We have chosen to divide the leaders' approach to management into two directions of management, respectively instrumental and institutional management. We will tie the transformational leadership approach to the institutional perspective and the transactional approach to the instrumental perspective. Even though the institutional perspective is to a greater extent represented in our findings, we think it is informative to compare these two perspectives to get a better understanding of managers' approach to change and sickness absence. The managers used different strategies to improve the work environment, and this finding is consistent throughout the comparison.

Preference for the Transformational/Institutional Approach

The workers under instrumental management have low decision latitude and little room for deviation from the described performance of the work tasks. The managers are supposed to facilitate so that the workers can work as efficiently as possible; this perspective uses the organization as an instrument to achieve its goal (Burns et al., 2012). Institutional management looks at pressure from outside and within the organization and tries to adapt to this (Burns et al., 2012). Selznick explains the institutional perspective by saying that "companies take a set of values, structure and capacities as a part of natural history of development" (Selznick (1957), in Burns et al., 2012, p. 18). This direction of management is more concerned with values and adapting to the surroundings, even if the original goals have to change. This is appropriate in times where the organization has to go through a change process (Burns et al., 2012). Female managers are usually more transformational in their approach to management than men (Bass, 1999). This is interesting and something we should remember when discussing the managers' approach to change in the primary health care, where all our participants were women. These managers are all nurses and many of them then have caring qualities because of their profession. It was therefore not that surprising that a large proportion of the managers preferred a transformational approach. It was however interesting to see that some took an approach that was more transactional than the rest of the

respondents. Transformational leadership is mainly directed by institutional values but appreciates some of the values from transactional leadership as well (Bass & Riggio, 2005).

Strategies to Improve the Work Environment

Many of the respondents used different strategies to achieve a successful change. All of these strategies displayed a pattern of concern for the work environment through what we will call supportive management, which includes features like having an open door, building a team feeling and motivation. This pattern matches the fact that most of the managers preferred the transformational approach. Supportive management is an important feature of the transformational leaders, which can help create trust among the employees. The managers also emphasized being visible out in the department and the importance of information. This emphasis often corresponds to the managers who described themselves as supporting, caring, cooperating and as a good role-model, which are qualities of the transformational approach to management (Bass & Riggio, 2005; Burns et al., 2012). Lastly we will discuss supportive management versus "scare culture". We find it instructive to make this comparison because here the difference between the transformational and transactional directions is most distinct.

Supportive Management

Some managers said that a supportive approach led to good results, specifically through efforts such as an open door policy where the employees can just drop by and talk, which can make them feel seen and heard. Walking around in the department to be visible was mentioned for similar reasons; being visible and open to the employees will give them a feeling of recognition and confirmation. Both of these strategies can make the threshold lower for the employees to just pop by or grab the manager's attention for informal chats. This is necessary according to the ERI-model to limit the negative consequences of a change process (Rydstedt et al., 2007). We also note that a pattern in the responses we received was that managers did not have time for long talks, and these strategies were more conducive to allowing for small talks instead. In addition to giving the feeling of recognition, the manager can feel the mood and check how the employees are doing. Employees value visible managers, according to Bogen and Lien (2015). It also makes it easier for the manager to catch problems and resistant feelings early on and deal with them. Other managers supported employees in other ways, with one-and-one dialog with all the employees in addition to extra

meetings. Efforts to create a good work environment have been strongly indicated to be good for the employees' health (Head et al., 2005).

Preference for Transactional/Instrumental Management

The managers that were more transactional did not emphasize being visible to the same degree. Some of them told us that they forgot their employees a little during the change process because they were too concerned with getting all the new routines and chaos from the change in order. They did this because they were more concerned about the importance of the basic framework, which they felt needed to be in order before they could support and be visible for the employees. Being clear and keeping all the instrumental aspects of the operation in order can be very important in a change process. Salaries need to be paid at the right time, sickness absence needs to be followed up, the manager has to delegate tasks and implement routines. These instrumental aspects are necessary for the employees to be able to do their job efficiently (Burns et al., 2012; Vahtera et al., 1999). It is also important for the employees to see that the manager has control and is making work easier by implementing the structure in everyone's workday. In a change process it is important to plan and implement routines to keep the structure at work and for the employees to follow the new routines (Bogen & Lien, 2015). Bogen & Lien (2015) also suggest that long-term planning gives employees more predictability; this was also emphasized by a few of the participants in this study. There were however, consequences of forgetting the employees, even when it was with good intentions to improve their workday. The managers said that these consequences were increased sickness absence and dissatisfied employees after the change was over. The employees in these departments got tired of waiting during the process without enough recognition in combination with uncertainty. These employees also struggled more with the work environment during and after the change process, which might have been because the manager was more engaged in the instrumental aspects of management in this time period.

Support with Information

One manager explained that she supported her employees by leading the way and giving information to the employees to decrease the uncertainty around the change process. These are two important aspects of managing that can help ensure a successful change process. The employees will need someone to lead and give information when they are going into something new. Information is crucial in a change process. This requires that the managers are able to present information without causing misunderstandings. One wants to reduce the

gap between what one thinks and feels, and what is expressed (Buchbinder & Shanks, 2011 p.47). When one presents information, the strategy should be to think about the goal, the content of the message, who is the audience and what is the right channel (Quinn et al., 2011). When communicating one has to clearly express without blaming and criticizing; first one has to observe, then one has to explain the feelings, needs and requests (Burns et al., 2012). Some of the managers said they have employees that seem like they are not able to remember, pay attention to or understand the information they get; others felt like there was not enough information to give. The information needs to be adequate and as good as possible to reduce uncertainty and motivate the employees for the change. However, it is debatable if it is enough to only focus on giving information and leading the way, as it might create a feeling of not being heard and listened to among the employees.

Transformational Leadership and Blurring Out the Lines

The transformational approach to management values support, dialog and seeing the advantage of blurring out the lines between all the different professions (Bass & Riggio, 2005). These factors can result in good work environments, which according to previous research and as previously stated is good for the employees' satisfaction at work (Steers & Rhodes, 1978). When asked, the managers could not say clearly if they saw a difference between the various health care professionals in regards to perceiving information and control over their work situation. They believe that this was more person dependent than profession dependent. We can imply here that the managers look at each of her subordinates as equal individuals with their own possibilities more than their education. This can be a good starting point when you are managing in the healthcare sector. It can help in giving the employees a feeling of control and the support they need in their workdays. A result from this can be a positive work environment and team feeling with motivated employees and then hopefully less sickness absence. This might also have a good effect on the nursing assistants. They represent a big proportion of the health care workers in nursing homes, and they are the ones that are most exposed to sickness absence (Fevang, 2003). To make them feel more valued and on the same level as nurses might help to prevent sickness absence among nurse assistants (Fevang, 2003). The DCS and ERI- models support this by emphasizing reward and a good self-experience as products of feeling valued (Rydstedt et al., 2007).

Impact of Social Support on Sickness Absence

Support from the manager can reduce the stress and feeling of uncertainty among the employees. Research has shown that support is one of the three most important factors to decrease sickness absence (Michie and Williams, 2003). Research done by Head and colleagues (2005) also assumes a decreased risk of sickness absence if there is an increase in the social support at work. Informal communication and good dialog between employees and manager is helpful for everyone to maintain or create a good work environment and catch problems early. Again, a good work environment can, according to Fevang (2003), reduce the risk of sickness absence. The reason is suggested to be that the employees feel a commitment to their colleagues and patients, and know that not showing up at work will make the day worse for others they care about. Too much support from the manager can, however, make it easier for the employee to go out on sick leave (Kjekshus & Berstrøm, 2011). Some employees might take advantage of the manager if she is too nice, and take an extra sick day every now and then when they feel tired.

Teamwork

If the manager is positive and is a team player it can be easier to follow the change through. According to the transformational leadership approach, the manager should always talk about changes as a group task, and emphasize that this is something everyone needs to do together. This is in accordance with the transformational leadership approach of blurring out the lines between the professions, as this is beneficial to teamwork (Bass, 1999; Bass & Riggio, 2005). Blurring out the lines can be useful when managing in a nursing home. It will likely improve the cooperation, which gives more efficient workdays. All the managers saw it as important to build team feeling and to say, "We are in this together." There was not a distinct difference in the managers that leaned more towards the transactional instead of transformational approach in this case. This might be explained by the fact that everyone gave the impression of being closer to the transformational approach when managing than the transactional approach. However, the managers with more transactional tendencies than the majority talked more about how important teamwork is for the organization while the rest focused more at the employees' satisfaction. One might say that transactional leaders are more concerned with the organization and the transformational leaders are more concerned with the individual.

Motivation

Motivation can be vital for a successful change process, as it is a state of mind that makes individuals work harder and perform better (Burns et al., 2012). Studies show that jobs in the

healthcare sector are often physically and mentally straining which increases the risk of unmotivated employees. Other studies show that motivated employees have a higher threshold for calling in sick. It is assumed that an employee is more motivated to come to work if he/she is happy with the work environment and likes the work tasks (Fevang, 2003; Steers & Rhodes, 1987; Marmot et al., 1995). Knowledge about how to motivate one's employees can therefore be useful and necessary to decrease the sickness absence. The hierarchy of needs is helpful to discover what motivates employees. Maslow (1943) divides needs into physiological needs, security needs, belongingness needs, esteem needs and self-actualization needs. This hierarchy shows the needs of the employees and says something about how the manager can motivate them (Burns et al., 2012). A large proportion of the participants agreed with the statement that motivated employees are more present at work. However, we got the impression that most of their strategies for motivation were ad-hoc. They had to take problems as they came along because they did not have time to sit down and make a strategy for motivation or have long motivational talks with heir employees. They focused mostly at the three middle needs: security, belongingness and esteem.

Professional and Personal Development

Organizational change can provide opportunities for professional development, new and interesting patient groups and improved care for the patients. Several managers mentioned that their employees were insecure about the new work tasks that resulted from changes. These cases would likely benefit from using medical courses and training to develop professionally and become safer at one's ability to do a good job. Health care workers typically have an intrinsic value and motivation behind their choice of profession; professional development might because of that work just as well as monetary reward (Buchbinder & Shanks, 2011). This also satisfies the self-actualization need in Maslow's hierarchy of needs (Burns et al., 2012). Some of the managers mentioned using this strategy, but not many.

Motivation through the Work Environment

Good work environment is one important factor that can motivate people to come to work (Steers & Rhodes, 1978; Rydstedt et al., 2007). Team feeling, support and adequate information can be helpful to create a good work environment. These are things the manager can affect to a certain extent, and many of the participants tried to do so. A few even planned social events outside work to improve the work environment and team feeling. Other

managers focused more on reward and punishment when they motivated the employees to go along with the change process. This is more in line with transactional management that uses reward for good work and punishment to correct poor work. This was effective in the way that the employees missed out on rewards when they did not do as they were supposed to. If they wanted the rewards enough, they had to adapt and do as told to, which most of them eventually did. This can work against its purpose in the long run, as it might lead dissatisfied employees, which again can cause gossip and poor work environment. However, it might also be necessary in some cases.

Meetings

Information to motivate employees mainly satisfied security needs because it decreased the uncertainty around the change. It is, as mentioned earlier, crucial to have good information during a change process. The employees will get worried and stressed from the uncertainty without good information, which can be bad for the health (Rydstedt et al., 2007; Robinson & Griffiths, 2005). Some managers implemented extra meetings every week. The purpose was that they wanted to have good communication with their employees to eliminate some resistance. They experienced that this improved the work environment and made people less concerned. This seemed to make the employees better equipped for the change and challenges. This corresponds to what the transformational leadership theory stresses as important (Burns et al., 2012). Another strategy that was used during the extra meetings was to show the employees the department's budget, so that everyone could feel responsible for how it is going. We noticed that managers with a leadership approach leaning more towards transactional used this strategy. They seemed to focus on budgets, what to do and how to change for the budget to look good. This could be problematic because health care personnel are usually more concerned about the treatment of their patients than the budget. Research done by Fevang (2003) reports that a big proportion of health care workers struggle with the feeling of never doing a good enough job because they lack the resources and are too few people at work. However, Bogen and Lien (2015) suggest in their study that budget-focus can work as motivation, because everyone gets on board in the same boat when working towards the same goal.

Support vs. "Scare Culture"

When asked, many respondents said that they trusted their employees to do a good job and were aware of the autonomy of health care personnel. This might be beneficial because

research shows that employees with high degree of stress and little decision latitude have three times higher sickness absence than employees with the same amount of stress and high decision latitude (Fevang, 2003). One might say that the health care personnel are the specialists and the manager is the generalist. Many of them were not fond of supervising or monitoring their employees; they would rather support them and guide them when needed. This corresponds with the transformational approach where autonomy in combination with challenges and support is emphasized. Some managers chose to manage "by walking around." They felt that this approach allowed them to be visible in the environment and remain updated on how things are going out in the department. The managers that leaned toward transactional management preferred to be completely honest and make demands; one respondent said that she "did not sweep anything under the rug" and another one said that she "got straight to the case." This managing approach could be difficult when managing nurses that might require high decision latitude because of their training (Rydstedt et al., 2007). However, other untrained professions such as assistants might need or want more guidance within the job. It can therefore be beneficial to be detail oriented like many transactional managers are. "Walking around" can be a good strategy for some managers if they have traits that built trust and the employees feel confident with their leader. However, if there is lack of trust between the manager and the employees this strategy can go wrong. It can be perceived as monitoring instead of supporting. The managers who were more towards the transactional approach emphasized making the employees feel responsible for a good work environment. They also wanted to increase the awareness of sickness absence and its consequences at the departments. At the same time these managers were also typically concerned about taking away extra stress for the employees and helping them pick out the most urgent work tasks when she saw the employees struggle with too much to do. This finding is in accordance with the Bogen and Lien (2015) study.

Uncertified sickness absence is believed in some cases to say more about the employee's feeling of illness than the actual disease (Steers and Rhodes, 1987; Marmot et al., 1995). One might then ask if there is something that needs to be done with the attitude among the employees. Several of the participants said that it has been necessary to work on the attitudes among their employees, as they thought some of this absence was because of poor attitude. A manager said that she had seen other managers keep their absence down in change processes by making this "scare culture." By making examples of employees not following the guidelines for sickness absence, one can scare the rest to follow the rules. This gave good

results for some of the managers, however it is doubtful if it is beneficial in the long-run as this can lead to poor work environment and stressed employees. A "scare culture" can make it difficult to achieve employee satisfaction. Research also indicates that people have a lower bar for taking uncertified sickness absence when they are not satisfied at work (Steers & Rhodes, 1978). The employees' feeling of illness might also be amplified if they do not like their job, something at their job or someone at their job. A situation with uncertainty and dissatisfaction, which can result in unmotivated employees, is likely to occur during a change process (Robinson & Griffiths, 2005; Schaufeli et al., 2009). But then again, it can be necessary as a few managers pointed out, to remind them that no one is forcing them to work there, it is voluntarily. It is not ok to call in sick for no reason. Another question to ask when discussing "scare culture" is if it is appropriate when managing women compared to men. The majority of the health care workers are women, and it is therefore necessary to consider this when choosing a management approach. Our experience was that most of the participants preferred softer qualities, like support and teamwork.

The Importance of Trust

It is especially difficult to manage a change process without a high level of trust between the manager and employees because of uncertainty, which can lead to suspiciousness. Being supportive and having an open door policy will most likely increase the trust from the employees to the manager, which was something that concerned all of the participants as they felt this was crucial for reducing sickness absence. Research by Aagestad et. al. (2014) done in Norway shows that low supportive leadership provides 50 percent increased risk of high absenteeism. Supportive management is here understood as giving feedback on the performed work, valuing the job results from the employee, treating everyone fairly and the importance of trust and respect. As mentioned earlier, the majority of the managers emphasized both being supportive and having an open door. They wanted the employees to come to them with problems, feelings or just to talk, because they thought this could create a better work environment and hopefully earn the trust from their employees. The result was that there were some differences in how they perceived the trust from the employees. The managers with the transformational approach seemed to be more secure on their level of trust. The managers that seemed more transactional in their way of managing reported more issues with getting to know what the employees felt. This complicated the attempt to facilitate the work to get the absent employees back faster.

Implications

Even though research on transformational leadership indicates that this is a good approach in managing, there is some evidence that says otherwise about managing change. These middle managers have a background in nursing, but they have taken different management programs and courses. Since there are many large changes going on in SYE it could have been an idea to train the managers in "change management." The managers answered vaguely about motivation strategies and one of the reasons for that might be the time pressure they experience, especially during a change process. To become better motivators they could have switched focus from the negative sides about change to the positive side of the process. One way to do that is to offer the employees professional development or to shift the negative focus towards things that are exciting e.g. new and interesting patient groups and improved care for the patients. Several managers mentioned that their employees were insecure about the new work tasks that resulted from changes. Medical courses and training could therefore work as motivation to meet the new work tasks. Health care workers typically have an intrinsic value and motivation behind their choice of profession; professional development might then work just as well as monetary rewards (Bogen & Lien, 2015). This can reduce sickness absence (Fevang, 2003). To motivate employees one has to know the emotions and social factors in human beings. One has to affect the behavior in a positive way to reach the goal of the change process. If they know about the Valley of Despair they can be better suited for change management. It will make it easier to recognize the necessary components for good motivation strategies.

From Absence to Presence

Uncertainty and Workloads

We asked the managers if they believed that there is a connection between uncertainty, increased workload, and sickness absence. There was a consistency in the answers from the managers that the change process led to uncertainty and that this could increase the absence. Many said that the employees used sickness absence as a protest against the change. They saw that their employees lost their job satisfaction in this process. Swedish research shows that nurse assistants and older nurses working with the elderly had increased absence during a change process, and a Canadian study shows that nurses felt less involved in their work and had increased rates of depression, anxiety, emotional exhaustion and work insecurity (Josephson et al., 2008; Bourbonnais et al., 2005). Uncertainty at work can cause negative

stress, which can lead to unsatisfied employees in the short-term and in the long-term it can mean that that employees do not perform optimally and are less committed to their jobs. It may also affect the physical and mental health of employees. The managers can improve work environment and decrease uncertainty by going through the change together as a team and supporting each other. This is an area that a transformational manager would emphasize (Bass, 1999; Steers & Rhodes, 1987; Fevang, 2003; Schaufeli et al., 2009; Rydstedt et al., 2007).

ERI- and DCS-inspired Solutions

The managers reported that it was useful to be aware of the change process being more straining for the employees, while simultaneously the change was more demanding for them as well. It creates imbalance between effort and reward, which is harmful for the employees' health (Rydstedt et al., 2007). The ERI-model recommends higher reward as a solution to decrease the effect. A manager with a transactional approach will likely agree with this model, as they used punishment and reward when managing and motivating the employees (Burns et al., 2012). They will then focus more at reward when going through change. Some of the managers focused at not changing the shift arrangements after the change or gave the employees the opportunity to come with suggestions for the new shift arrangement. Other managers used the opportunity for the employees to work more and other small rewards. The DCS-model looks at the relationship between job demand, control and social support. During a change process when both job demand increases and job control decreases, the DCS-model recommends more support from the manager to decrease the effect from the change on the employee. This model is more in line with what the manager with a transformational approach would focus on for more satisfied employees (Bass & Riggio, 2005; Rydstedt et al, 2007). These managers emphasized supportive and visible management during the change process. Studies also show that people with high support experience better health during stressful events (Vakola & Nikolaou, 2005). We believe that support is necessary during the change, however rewards can also positively affect the employee. All the managers gave the impression that shift arrangements were a big concern for most of their employees. Trying to meet the employees' wishes as far as possible can make them more satisfied and motivated for the change.

Strategies towards Sickness Absence

Our study emphasizes that the process of organizational change and how change actually happens comes with an increased risk of sickness absence for those it is affecting (Barnett & Carrol, 1995). It is often experienced as stressful for the employees affected (Robinson & Griffiths, 2005). Managers should be aware of this and take action. The current trend of shifting the focus from absent employees to present employees in attempt to prevent sickness absence was emphasized by several managers. Some managers focused more at facilitating for the absent employee so he or she could attend work regardless of the reason they had to be absent. Facilitating can be argued to be more transactional than support and teamwork. Transactional leaders were more concerned with the legal framework, which often emphasizes facilitating for the absent employee. The managers that felt more bounded by the laws were then more concerned about facilitating and used this as their main strategy. This strategy is important and can be helpful to reduce or prevent more sickness absence. However, this approach can take the focus away from the present employees when they do not place enough emphasis on visibility and support for those who attend work, which is why the transformational leaders liked the 'from absence to presence' approach. Ultimately, it is likely a combination that will yield the best results for reducing sickness absence. By combining transformational management and transactional management, one can be a more successful change manager. It depends on the person or the situation a manager find herself in (Bogen & Lien, 2015).

Use of Temporary Workers

One thing some managers chose to do was to not hire temporary workers, either because of the budget or because there was no one available. Research shows that the main reason for not hiring skilled temporary workers seems to be financial pressure from above. The manager and nurses at work feel pressured to prevent the use of temporary workers to cover absent employees because the agencies are very expensive to use (Gautum & Bratt, 2014; Fevang, 2003; Bogen & Lien, 2015; Josephson et al., 2008). We can assume that it is mostly the managers with a more transactional approach that feel this way as transactional managers tend to be more concerned with waste of resources. From the interviews, we got the impression that these managers were more concerned about the budget than their peers with a transformational approach to managing were. The consequences of this are increased workload on the present employees due to smaller staff. In cases where they hire in a temporary unskilled worker to cover for an absent nurse, this will increase the workload and

responsibility for the present nurses. The present nurses will have more patients to be responsible for and a more stressful workday, despite the extra unskilled worker.

Research done by Head and colleagues (2005) shows that while increased workload does not necessarily increase the rates of sickness absence; it does so when the extra workload is unwanted. Not hiring extra people when employees are sick in order to save money can actually have the effect of even more sickness absence due to unwanted increased workloads. This is costly, both for the government and the institution (Fevang, 2003). However, there is also a non-financial reason for not hiring extra people: because demand for nurses from the temp agencies is simply too high, these agencies often lack nurses that want to work during weekends (Gautun & Bratt, 2014). Another reason is that care of the patients given by many different health care workers instead of a small group is likely to be less consistent and details and information about the health status can be lost. Errors can then be made as a result of the loss of this information. These factors were reported to be a problem, and something some managers worried about. Also, some managers suggest that the nurses that come from these agencies often do not feel the same loyalty to the workplace, because they move around so often. It can therefore be difficult to use these nurses and easier for the manager to hire a known, but unskilled assistant to cover for the ones who are sick. Some managers joined in and helped in the department because of this. They did not want their employees or patients to suffer because of the sickness absence. This shows a transformational approach, and by doing this they also built up the team feeling and blurred out the line between the manager and employee.

Tett På

The project tett på, in cooperation with NAV, helped the managers facilitate for their employee to come back faster (Arbeidsmiljøutvalget, 2015). The main goal was to make it easier for the managers to start early an dialogue with the absent employee by sending in a simple form to NAV. However, this sometimes turned out to be more straining and time consuming for the managers than was intended. One emphasized on getting the absent employee back to work as early as possible, but this requires more work for the managers, so how can they use more time on the present employees? We understood from the interviews that the trend of focusing on the present employees rather than absent did not only concern SYE. This focus is a shift in almost all of the labor market nowadays (Inkluderende arbeidsliv, 2015; Oslo commune, 2014b). The managers with a transactional approach,

however, seemed to appreciate the instrumental aspects of tett på. It seemed like they preferred the tidiness of the new system, where they could send in predetermined forms to solve the problem of sickness absence. The managers used themselves as facilitators and stressed the importance of early conversations, dialogue and follow up. The managers with a transformational approach on the other hand saw this as a hindrance to focusing on the employees that were present, because they used their time on getting the absent employee back as soon as possible. By filling out all the forms and follow-up that tett på requires, this left too little time to be supportive and visible in the department.

Implications

In recent years sickness absence has become something that is not only a private matter for the individual, but also the organization. It is now taken for granted that the employee discuss his or her sickness absence with their manager—in fact the employee is obliged to cooperate with the manager. The managers are allowed to ask about the function of the employee who is absent from work (Bogen & Lien, 2015; Arbeidsmiljøutvalget, 2015). It is implied and a responsibility that all the actors cooperate with each other to accommodate the problem of absence in the primary health care sector. SYE cooperates with NAV, BHT and the employees' physicians to solve the high rates of sickness absence. This has become a collective responsibility between the manager, employee and external actors. There is to a large extent transparency in sickness absence now. The manager can track the sickness absence in different programs and get out almost all statistical data they want about sickness absence. The employees have a right to know the rate of sickness absence at their department and records of sickness absence are very easy to find in different databases. This transparency and information they can retrieve can make it easier to approach sickness absence. These systems are made to make it easier for managers to find appropriate information and guidelines to approach sickness absence, but we see that it is time consuming and it still shows signs of bureaucracy. If they manage to use this information properly and efficiently they can find ways to get them back to work, but if they do this it will take time away from the present employees. As previously stated, the focus on sickness absence is changing towards a focus on the present employees. However, the managers find it very challenging to do this while still having to document, monitor and report every aspect of sickness absence. If they had used less time on the absent employees and more time on the present employees the change process could be more successful and less employees would get sick from the change.

They have to find a middle way of using these systems and guidelines to their own benefit. Only then they can focus on the employees who are present.

8.1 Methodological Considerations

Reflexivity

One has to know one's own baggage with conceptions, assumptions and preconceptions to meet the reflexivity criteria. We have to think about our relationship to the respondents and how this relationship affects the answers they give. To be reflexive means to make the research process into the main focus. The interviews helped us produce new knowledge. To meet these quality criteria we changed the interview guide as the study proceeded. Reflexivity can among other things be the relationship the researchers have to the interview respondents. One of the researchers is a manager and is therefore a colleague with the interview participants. Another thing to keep in mind is that all our respondents were female, and since the researchers also are females, this can affect the answers. We also had to keep in mind that there is a reason for choice and interest of topic and research question. We have studied health management and economics for five years and specialized in management, which can affect how we interpret the data we collect and how we frame the questions in the interview guide (Justesen & Mik-Meyer, 2012).

We started the interviews by introducing ourselves and the aim of the study. We told them that we were students from the program of Health Economics, Policy and Management. The participants sometimes asked us more about our professional background. When asked about this we told them that one of the researchers is a manager and the other an assistant at a nursing home. Some of them got worried because our knowledge on this field is extensive and they felt that they did not have enough theoretical knowledge to provide good answers. It might have been an advantage that one of us had the same professional background and the other did not have this background. Having a neutral background can help make it less intimidating. Having this professional background and knowledge about this sector can on the other hand help catching important aspects that otherwise would be ignored or overlooked. Prior experience with restructuring and one's profession can be problematic, but it can also be a strength for the study. It was important for us to keep this in mind and assess this effect at every step (Justesen & Mik-Meyer, 2012).

The leaders that got interviewed might lack introspection and think that they are better than they really are. They might on the other hand be affected by "janteloven" and say that they are not that good and that the job they are doing is not that important and so on. It is therefore very important to enlighten all the aspects. Our participants are from Norway and should therefore be understood in light of a Scandinavian context. Bragging and showcasing are a rare behavior in a Nordic culture, where they are more influenced by "janteloven", which has a saying that "you shall not believe that you are better than anyone else." These norms may be an explanation for why we did not find more purebred managers, describing themselves as only transformational or transactional leaders (Nelson & Shavitt, 2002). Gullestad (1992) calls this equality based on conformity.

Because this is a sensitive subject it is important to take into account all the aspects of confidentiality. It was a challenge to find participants that want to be included in this study. We experienced some middle managers that thought this subject was too intimate. Some managers also felt insecure about the subject and therefore declined. A problem with our sampling strategy was that some of the institution managers could forget to forward the email about participating or may not find it meaningful. A limitation in this study is that we lost some participants because we have narrowed down the sample to be middle managers and not all managers in this sector. As we said earlier it can also be a limitation that the participants that declined can have valuable information or bring in another aspect than the ones who participate. Qualitative studies are also particularly hard to generalize outwards or understand outside of their context. The research design was appropriate because the interviews revealed that the middle managers possessed different experience and perceptions about sickness absence and change. We got many additional findings related to managing in primary health care. We had a large sample consisting of 16 middle managers. However, they were all females, which can give less variation in the answers. Another limitation was that all the participants were only interviewed once. To uncover more topics related to this field, we could have focus groups or follow-up interviews (Justesen & Mik-Meyer, 2012).

Internal and External validity

To what extent are the findings shedding light on the research question? Are we investigating what we are meant to? These are questions relevant for internal validity. External validity asks about the application of findings in different contexts (Malterud, 2001). We achieved internal validity in different ways in this qualitative research. First, we talked about how we

could affect the answers we got, because of our knowledge and background. Second, it might have been an advantage that we were two researchers in this process, benefiting from researcher triangulation. We talked and discussed the choices and the findings with each other every step of the way. This way we ensured not to misunderstand the findings or misinterpret the answers. Third, since we were two researchers on the interviews, we had the opportunity to take notes during the interviews, which gave us the opportunity to write down follow-up questions. If we did not get a clear and understandable answer, we asked the participants to elaborate on the question. We also did this when they told us something interesting. This occurred often after the interview was finished. Lastly, we also had a pilot interview with a middle manager. That helped us to get to know interview as a method and test the interview guide before execution. External validity concerns whether the results are valid outside the context of the study. As mentioned earlier, we believe that this study is applicable to different sectors and at different management levels, because the systems are very similar across the public sectors and the values are typical Norwegian. Since we also interviewed middle managers in the private sector we believe the nuances were taken into consideration and this is a strength and an argument for transferring this study further to include also the private sectors. However, it may be most appropriate to use this study in Norway, because transferring the same knowledge to different systems and cultures may be a challenge (Justesen & Mik-Meyer 2012).

9 Conclusion

Our main findings were that motivational management and information was crucial in a change process. The managers who had substantial knowledge about the Valley of Despair model felt more secure when handling difficult situations that occurred as a result of the change process. Most of the managers had a transformational leadership approach, which is believed to be appropriate when managing health care personnel. They used several strategies to reduce or prevent sickness absence, mainly support, communication/information and teamwork. According to previous research, theory, and our findings, supportive management is valued by the employees, and is indicated to be necessary for preventing sickness absence. It is important to know how to approach sickness absence and increase knowledge about change processes. The rate of both change and sickness absence are high in the healthcare sector, and the correlation between them make it very challenging and complex. The managers who had abilities and knowledge about change, felt that they were better suited to prevent sickness absence in a change process. The leaders who managed to create a basic framework by giving out adequate information and have good communication with their employees more often felt that they obtained trust. We believe that this approach together with using methods of motivation can increase the chances of a successful change process.

The Coordination Reform is only the beginning of a time where the municipalities and middle managers have to handle changes in organization, new technology and increased demand on health care personnel. More responsibility on the primary health care sector is an emerging trend that will continue. This requires abilities and competence to act from the managers. In the future they will need better and more efficient systems that are linked together. Currently these systems are not in place. The employees will need improved technology to take care of more complicated patients. Currently the managers in SYE have to take care of the economy, administration, personnel and quality in their department. This is almost impossible if the trend continues. They will need better support systems, like HR-support, legal support, administration support and communication support to handle the large and complex changes that may arise. If they want to succeed with paying more attention to present employees than absent employees, they will have to change not only the mindset, but also premises that they are suffering under now.

We will find it interesting to research further on how the managers can change focus from absent employees to present employees while still satisfying the bureaucracy. It could also be interesting to look at how well the bureaucracy actually works and if it possible to change it to be a more suitable system for its purpose. One of our most consistent findings was the need for information. It would therefore be informative to look at how the managers use information as a strategy to achieve a successful change process. Further it would have been interesting to look at which traits female middle managers have and if they use different approaches than their male peers. It can also be important to conduct research from the workers' perspective. That way we can find out how much information is needed to minimize the uncertainty. It would also be possible to find out how to consider and handle the employees better by doing a survey on what they think was good and not so good during the change process. Since female workers are overrepresented in the healthcare sector, it could be useful to look at strategies to approach female workers or work groups. Another interesting aspect could be to research more on motivational strategies and how the managers perceive the effect of them. Research where one combines quantitative research with qualitative research in this field can be effective. It can be valuable to measure the effect of sickness absence in terms of numbers, e.g. difference in yearly sick days after the introduction of a new change. Lastly, it is also possible to look at how much sickness absence has cost through quantitative measures such as use of temp agencies and qualitative measures like loss of quality for the patients.

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Appendix

Appendix I: Participant Information and Consent Form

Appendix II: Registration Form

Appendix III: Interview Guide

I Participant Information and Consent Form

Forespørsel om deltakelse i forskningsprosjektet

"Leaders Approach to Change"

Bakgrunn og formål

Vi er to masterstudenter ved Medisinsk fakultet, Institutt for helse og samfunn, ved Universitet i Oslo som skal gjøre en studie om hvordan omstillingsprosesser påvirker sykefravær og hva lederen kan gjøre for å redusere fraværet. Som et ledd i denne studien vil vi intervjue ca. 15 avdelingssykepleiere fra ulike sykehjem i Oslo kommune. Høyt sykefravær og stadig omorganiseringer innenfor primærhelsetjenesten gjør dette til et viktig og høyst aktuelt tema.

Studien vil se på ulike teorier om ledelse og hvorfor endring i organisasjonen ofte fører til økt sykefravær. Intervjuer vil bli utført for å få en dypere forståelse av dette temaet og forhåpentligvis en idé om hva slags tilnærming til ledelse som egner seg best under endringsprosesser. I tillegg ser vi etter tiltak som kan bidra til å redusere sykefravær og gi de ansatte en bedre opplevelse av endringsprosessen. På den måten kan endringen bli brukt positivt også for den ansatte og ikke bare institusjonen, noe som igjen kan gi mer vellykkede endringsprosesser.

Hva innebærer deltakelse i studien og hva skjer med informasjonen om deg?

Vi kommer til å bruke båndopptager under intervjuene og hvert intervju vil ta ca. 45 min. Vi gjør selvsagt intervjuet der det passer best for lederen, og gjerne der lederen jobber. Det har blitt forsket lite på ledelse av sykehjem ved omstillinger, så vi håper du ser på dette som en unik mulighet til å kunne bidra. Vi er underlagt taushetsplikt og alle opplysninger vil bli behandlet strengt konfidensielt. Resultater fra intervjuene vil

presenteres anonymt, og det vil ikke bli gitt spesifikk informasjon som kan spores tilbake til den enkelte deltaker eller sykehjem. Etter at vi er ferdige med studien, så destruerer vi alt datamaterialet.

Prosjektet skal etter planen avsluttes 31.12.2015 og vi håper på å få gjort intervjuene før sommeren 2015. Studien er meldt til Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Ta kontakt med Michelle Håkull på michelle.hakull@studmed.uio.no eller på mobilnummer 91871859 dersom du kan tenke deg å delta. På forhånd takk.

Mvh Gitte T. Larsen og Michelle Håkull

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien, og er villig til å delta

---
(Signert av prosjektdeltaker, dato)

☐ Jeg samtykker til å delta i intervju

II Registration Form

MELDESKJEMA

Meldeskjema (versjon 1.4) for forsknings- og studentprosjekt som medfører meldeplikt eller konsesjonsplikt (jf. personopplysningsloven og helseregisterloven med forskrifter).

1. Prosjekttittel		
Tittel	Leaders approach to change	
2. Behandlingsansvarlig institusjon		
Institusjon	Universitetet i Oslo	Velg den institusjonen du er tilknyttet. Alle nivå må oppgis. Ved studentprosjekt er det studentens tilknytning som er avgjørende. Dersom institusjonen ikke finnes på listen, vennligst ta kontakt med personvernombudet.
Avdeling/Fakultet	Det medisinske fakultet	
Institutt	Institutt for helse og samfunn	
3. Daglig ansvarlig (forsker, veileder, stipendiat)		
Fornavn	Ivan	Før opp navnet på den som har det daglige ansvaret for prosjektet.Veileder er vanligvis daglig ansvarlig ved studentprosjekt. Veileder og student må være tilknyttet samme institusjon. Dersom studenten har ekstern veileder, kan biveileder eller fagansvarlig ved studiestedet stå som daglig ansvarlig.Arbeidssted må være tilknyttet behandlingsansvarlig institusjon, f.eks. underavdeling, institutt etc. NB! Det er viktig at du oppgir en e-postadresse som brukes aktivt. Vennligst gi oss beskjed dersom den endres.
Etternavn	Spehar	
Akademisk grad	Doktorgrad	
Stilling	Universitetslektor	
Arbeidssted	Universitetet i Oslo	
Adresse (arb.sted)	Forskningsveien 3A	
Postnr/sted (arb.sted)	0373 Oslo	
Telefon/mobil (arb.sted)	22850560 / 22850560	
E-post	ivan.spehar@medisin.uio.no	
4. Student (master, bachelor)		
Studentprosjekt	Ja ● Nei ○	NB! Det er viktig at du oppgir en e-postadresse som brukes aktivt. Vennligst gi oss beskjed dersom den endres.
Fornavn	Michelle	
Etternavn	Håkull	
Akademisk grad	Høyere grad	
Privatadresse	Vassbunnsvingen 10	
Postnr/sted (privatadresse)	1388 Borgen	
Telefon/mobil	91871859 /	
E-post	michelle_haakull@hotmail.com	
5. Formålet med prosjektet		
Formål	Formålet med prosjektet er å se på sykefravær under en organisasjonsendring og hva lederen kan gjøre for å redusere dette fraværet. Semi-strukturerte intervjuer vil bli brukt for å se på dette. Delmål som vil bli brukt er om lederne tror de kan påvirke sykefravær, om det er en sammenheng mellom stress og sykefravær og om det er visse lederkvaliteter som er bedre egnet under endring enn andre. Vi vil også se på om det er en sammenheng mellom opplevelsen av mestring av ledelse og vedkommenes lederstil.	Redegjør kort for prosjektets formål, problemstilling, forskningsspørsmål e.l. Maks 750 tegn.
6. Prosjektomfang		
Velg omfang	● Enkel institusjon ○ Nasjonalt samarbeidsprosjekt ○ Internasjonalt samarbeidsprosjekt	Med samarbeidsprosjekt menes prosjekt som gjennomføres av flere institusjoner samtidig, som har samme formål og hvor personopplysninger utveksles.
Oppgi øvrige institusjoner		

Oppgi hvordan samarbeidet foregår		
7. Utvalgsbeskrivelse		
Utvalget	Vi vil intervjue 15 avdelingsledere på ulike sykehjem i Oslo kommune.	Med utvalg menes dem som deltar i undersøkelsen eller dem det innhentes opplysninger om. F.eks. et representativt utvalg av befolkningen, skoleelever med lese- og skrivevansker, pasienter, innsatte.
Rekruttering og trekking	Avdelingslederne som blir valgt ut har vært gjennom endring det siste året.	Beskriv hvordan utvalget trekkes eller rekrutteres og oppgi hvem som foretar den. Et utvalg kan trekkes fra registre som f.eks. Folkeregisteret, SSB-registre, pasientregistre, eller det kan rekrutteres gjennom f.eks. en bedrift, skole, idrettsmiljø, eget nettverk.
Førstegangskontakt	Først vil de motta en epost med informasjon om prosjektet. Deretter tar vi kontakt over telefon for å planlegge møte.	Beskriv hvordan førstegangskontakten opprettes og oppgi hvem som foretar den. Les mer om dette på våre temasider.
Alder på utvalget	□ Barn (0-15 år) □ Ungdom (16-17 år) ■ Voksne (over 18 år)	
Antall personer som inngår i utvalget	15 stk	
Inkluderes det myndige personer med redusert eller manglende samtykkekompetanse?	Ja ○ Nei ●	Begrunn hvorfor det er nødvendig å inkludere myndige personer med redusert eller manglende samtykkekompetanse. Les mer om Pasienter, brukere og personer med redusert eller manglende samtykkekompetanse
Hvis ja, begrunn		
8. Metode for innsamling av personopplysninger		
Kryss av for hvilke datainnsamlingsmetoder og datakilder som vil benyttes	□ Spørreskjema ■ Personlig intervju □ Gruppeintervju □ Observasjon □ Psykologiske/pedagogiske tester □ Medisinske undersøkelser/tester □ Journaldata □ Registerdata □ Annen innsamlingsmetode	Personopplysninger kan innhentes direkte fra den registrerte f.eks. gjennom spørreskjema, intervju, tester, og/eller ulike journaler (f.eks. elevmapper, NAV, PPT, sykehus) og/eller registre (f.eks. Statistisk sentralbyrå, sentrale helseregistre).
Annen innsamlingsmetode, oppgi hvilken		
Kommentar		
9. Datamaterialets innhold		
Redegjør for hvilke opplysninger som samles inn	Ikke opplysninger av personlig art. Data vil bli samlet inn med hjelp av semistrukturerte intervjuer. Dataen vil handle om organisasjonsendring og utfordringer som oppsto. Det vil også handle om hvordan lederen handlet under endringen og om det var noen endring i sykefraværet. Pasientopplysninger vil ikke bli samlet inn. (se vedlegg 2).	Spørreskjema, intervju-/temaguide, observasjonsbeskrivelse m.m. sendes inn sammen med meldeskjemaet. NB! Vedleggene lastes opp til sist i meldeskjema, se punkt 16 Vedlegg.
Samles det inn direkte personidentifiserende opplysninger?	Ja ○ Nei ●	Dersom det krysses av for ja her, se nærmere under punkt 11 Informasjonssikkerhet. Les mer om hva personopplysninger er NB! Selv om opplysningene er anonymiserte i oppgave/rapport, må det krysses av dersom direkte og/eller indirekte personidentifiserende opplysninger innhentes/registreres i forbindelse med prosjektet.
Hvis ja, hvilke?	□ 11-sifret fødselsnummer □ Navn, fødselsdato, adresse, e-postadresse og/eller telefonnummer	
Spesifiser hvilke		

Samles det inn indirekte personidentifiserende opplysninger?	Ja ○ Nei ●	En person vil være indirekte identifiserbar dersom det er mulig å identifisere vedkommende gjennom bakgrunnsopplysninger som for eksempel bostedskommune eller arbeidsplass/skole kombinert med opplysninger som alder, kjønn, yrke, diagnose, etc. Kryss også av dersom ip-adresse registreres.
Hvis ja, hvilke?		
Samles det inn sensitive personopplysninger?	Ja ○ Nei ●	
Hvis ja, hvilke?	□ Rasemessig eller etnisk bakgrunn, eller politisk, filosofisk eller religiøs oppfatning □ At en person har vært mistenkt, siktet, tiltalt eller dømt for en straffbar handling □ Helseforhold □ Seksuelle forhold □ Medlemskap i fagforeninger	
Samles det inn opplysninger om tredjeperson?	Ja ○ Nei ●	Med opplysninger om tredjeperson menes opplysninger som kan spores tilbake til personer som ikke inngår i utvalget. Eksempler på tredjeperson er kollega, elev, klient, familiemedlem.
Hvis ja, hvem er tredjeperson og hvilke opplysninger registreres?		
Hvordan informeres tredjeperson om behandlingen?	□ Skriftlig □ Muntlig □ Informeres ikke	
Informeres ikke, begrunn		

10. Informasjon og samtykke

Oppgi hvordan utvalget informeres	■ Skriftlig ■ Muntlig □ Informeres ikke	Vennligst send inn informasjonsskrivet eller mal for muntlig informasjon sammen med meldeskjema. NB! Vedlegg lastes opp til sist i meldeskjemaet, se punkt 16 Vedlegg. Dersom utvalget ikke skal informeres om behandlingen av personopplysninger må det begrunnes. Last ned vår veiledende mal til informasjonsskriv
Begrunn		
Oppgi hvordan samtykke fra utvalget innhentes	■ Skriftlig □ Muntlig □ Innhentes ikke	Dersom det innhentes skriftlig samtykke anbefales det at samtykkeerklæringen utformes som en svarslipp eller på eget ark. Dersom det ikke skal innhentes samtykke, må det begrunnes.
Innhentes ikke, begrunn		

11. Informasjonssikkerhet

Direkte personidentifiserende opplysninger erstattes med et referansenummer som viser til en atskilt navneliste (koblingsnøkkel)	Ja ○ Nei ●	Har du krysset av for ja under punkt 9 Datamaterialets innhold må det merkes av for hvordan direkte personidentifiserende opplysninger registreres. NB! Som hovedregel bør ikke direkte personidentifiserende opplysninger registreres sammen med det øvrige datamaterialet.
Hvordan oppbevares navnelisten/ koblingsnøkkelen og hvem har tilgang til den?		
Direkte personidentifiserende opplysninger oppbevares sammen med det øvrige materialet	Ja ○ Nei ●	
Hvorfor oppbevares direkte personidentifiserende opplysninger sammen med det øvrige datamaterialet?		

Oppbevares direkte personidentifiserbare opplysninger på andre måter?	Ja ○ Nei ●	
Spesifiser		
Hvordan registreres og oppbevares datamaterialet?	□ Fysisk isolert datamaskin tilhørende virksomheten □ Datamaskin i nettverkssystem tilhørende virksomheten □ Datamaskin i nettverkssystem tilknyttet Internett tilhørende virksomheten □ Fysisk isolert privat datamaskin ■ Privat datamaskin tilknyttet Internett □ Videoopptak/fotografi ■ Lydopptak □ Notater/papir □ Annen registreringsmetode	Merk av for hvilke hjelpemidler som benyttes for registrering og analyse av opplysninger. Sett flere kryss dersom opplysningene registreres på flere måter.
Annen registreringsmetode beskriv		
Behandles lyd-/videoopptak og/eller fotografi ved hjelp av datamaskinbasert utstyr?	Ja ● Nei ○	Kryss av for ja dersom opptak eller foto behandles som lyd-/bildefil. Les mer om behandling av lyd og bilde.
Hvordan er datamaterialet beskyttet mot at uvedkommende får innsyn?	Vi vil bruke en datamaskin og den er passordbeskyttet. Den vil bli oppbevart i et låsbart rom. Opptakene vil overføres til denne datamaskinen og kun befinne seg 1 plass.	Er f.eks. datamaskintilgangen beskyttet med brukernavn og passord, står datamaskinen i et låsbart rom, og hvordan sikres bærbare enheter, utskrifter og opptak?
Dersom det benyttes mobile lagringsenheter (bærbar datamaskin, minnepenn, minnekort, cd, ekstern harddisk, mobiltelefon), oppgi hvilke	Båndopptaker og en PC.	NB! Mobile lagringsenheter bør ha mulighet for kryptering.
Vil medarbeidere ha tilgang til datamaterialet på lik linje med daglig ansvarlig/student?	Ja ● Nei ○	
Hvis ja, hvem?	Gitte Tvetenstrand Larsen (medprosjektdeltaker) Ivan Spehar (veileder)	
Overføres personopplysninger ved hjelp av e-post/Internett?	Ja ○ Nei ●	F.eks. ved bruk av elektronisk spørreskjema, overføring av data til samarbeidspartner/databehandler mm.
Hvis ja, hvilke?		
Vil personopplysninger bli utlevert til andre enn prosjektgruppen?	Ja ○ Nei ●	
Hvis ja, til hvem?		
Samles opplysningene inn/behandles av en databehandler?	Ja ○ Nei ●	Dersom det benyttes eksterne til helt eller delvis å behandle personopplysninger, f.eks. Questback, Synovate MMI, Norfakta eller transkriberingsassistent eller tolk, er dette å betrakte som en databehandler. Slike oppdrag må kontraktsreguleres Les mer om databehandleravtaler her
Hvis ja, hvilken?		
12. Vurdering/godkjenning fra andre instanser		
Søkes det om dispensasjon fra taushetsplikten for å få tilgang til data?	Ja ○ Nei ●	For å få tilgang til taushetsbelagte opplysninger fra f.eks. NAV, PPT, sykehus, må det søkes om dispensasjon fra taushetsplikten. Dispensasjon søkes vanligvis fra aktuelt departement. Dispensasjon fra taushetsplikten for helseopplysninger skal for alle typer forskning søkes Regional komité for medisinsk og helsefaglig forskningsetikk
Kommentar		

Søkes det godkjenning fra andre instanser?	Ja ○ Nei ●	F.eks. søke registereier om tilgang til data, en ledelse om tilgang til forskning i virksomhet, skole, etc.
Hvis ja, hvilke?		
13. Prosjektperiode		
Prosjektperiode	Prosjektstart:01.01.2015 Prosjektslutt:31.12.2015	Prosjektstart Vennligst oppgi tidspunktet for når førstegangskontakten med utvalget opprettes og/eller datainnsamlingen starter. Prosjektslutt Vennligst oppgi tidspunktet for når datamaterialet enten skal anonymiseres/slettes, eller arkiveres i påvente av oppfølgingsstudier eller annet. Prosjektet anses vanligvis som avsluttet når de oppgitte analyser er ferdigstilt og resultatene publisert, eller oppgave/avhandling er innlevert og sensurert.
Hva skal skje med datamaterialet ved prosjektslutt?	■ Datamaterialet anonymiseres □ Datamaterialet oppbevares med personidentifikasjon	Med anonymisering menes at datamaterialet bearbeides slik at det ikke lenger er mulig å føre opplysningene tilbake til enkeltpersoner.NB! Merk at dette omfatter både oppgave/publikasjon og rådata. Les mer om anonymisering
Hvordan skal datamaterialet anonymiseres?	Vi skal ikke bruke personopplysninger (som kjønn, alder, bosted, sivilstatus o.l). Dataen blir bearbeidet sli at det ikke er mulig å føre opplysningene tilbake til den enakelte leder. Vi sletter all data etter prosjektslutt. Avdelingslederen vil få informasjon om prosjektet og kontaktpersonene og hvordan de kan kontaktes. Han/hun vil også få informasjon om at intervjuet er anonymt og at data vil bli slettet rett etter bruk. Det vil også bli opplyst om at det er frivillig deltakelse og at det går an å trekke seg når som helst.	Hovedregelen for videre oppbevaring av data med personidentifikasjon er samtykke fra den registrerte. Årsaker til oppbevaring kan være planlagte oppfølgningsstudier, undervisningsformål eller annet. Datamaterialet kan oppbevares ved egen institusjon, offentlig arkiv eller annet. Les om arkivering hos NSD
Hvorfor skal datamaterialet oppbevares med personidentifikasjon?		
Hvor skal datamaterialet oppbevares, og hvor lenge?		
14. Finansiering		
Hvordan finansieres prosjektet?	Eventuelle utlegg betales av studenten selv.	
15. Tilleggsopplysninger		
Tilleggsopplysninger		
16. Vedlegg		
Antall vedlegg	2	

III Interview guide

INTERVJU GUIDE

1. Kan du fortelle om endringen din avdeling har gått gjennom? Hva slags endring var det?
2. Hvordan definerer du endring? Hvor stor påvirkning tror du det hadde på dine ansatte?
3. Hvordan reagerte de ansatte på endringen? Følte de at de mistet kontrollen? Ble de stresset? Redde? Motvillige? Positive? Spente? Motiverte? -Var det endring i sykefraværet under eller etter endringen?
4. Hva slags lederstil vil du si at du har? Tok du en aktiv rolle under endringen?
5. Hvor mye informasjon delte du? Visste du mer enn de ansatte?
6. Hva tror/mener du er den beste ledestilen under endring?
7. Er sykefravær et lederansvar?
8. Føler du det som et nederlag ved høyt sykefravær? Hvordan påvirker det det du gjør?
9. Påvirker sykefraværet din jobb som leder?
10. Hva tror du er årsaken til økt sykefravær under og etter en endring?
11. Tror du at du kan påvirke andel langtidssykemeldte?
12. Hva er det viktigste du som leder har gjort for å redusere sykefravær?
13. Tror du det er en sammenheng mellom usikkerhet, økt arbeidsmengde og sykefravær?
14. Når i endringsprosessen tror du at de ansatte blir syke?
15. Har endringsprosessen vært en stor påkjenning for deg?
16. Hvordan motivere de ansatte under endring?
17. Tror du selv at motiverte ansatte forebygger sykefravær?
18. Hvor viktig tror du det er å ha kontroll over sin jobbsituasjon?
19. Hvor viktig tror du tillit mellom leder og ansatt er under endring?
20. Noe annet å tilføye?