

# **A COMPARATIVE CASE STUDY OF HOSPITAL MERGERS IN ENGLAND AND ONTARIO**

## **DYNAMICS OF INTERACTION BETWEEN GOVERNMENT AGENCIES AND OTHER GROUP ACTORS**

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## **DECLARATION**

This work has not been previously accepted in substance for any degree and is not being currently submitted in candidature for any degree.

Signed:

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**ABSTRACT**

This is a comparative case study of public sector hospital mergers in England and Ontario in the 1990s. Its purpose is to explore how change evolved and the organisational consequences as the hospitals underwent restructuring. The main focus is on the consultation process prior to the decision to merge. The objectives of this work were to analyse the interaction of government agencies and key stakeholders (as defined) in the period leading up to the merger and to track the restructuring process to determine if a new organisational form emerged. Multiple sources of data were collected and collectively the data spanned 19 years for both cases. The researcher conducted 79 interviews in 24 different hospitals and health care organisations over a period of 5 years.

The researcher draws on archetype theory and Neil Fligstein's work on power and the social skill of actors to construct a framework for analysis. Archetype theory focuses on intra-organisational dynamics of change and is useful for analysing the emergence of new or hybrid organisational archetypes, but does not focus on the role of external power and politics in the change process. Fligstein's work emphasises the importance of power and how actors may induce co-operation in others to influence and manipulate the change process.

The results of this research show that in similar market contexts there were significant differences (in the pre-merger review and consultation processes and in the organisational outcomes) between change that was 'stakeholder-led' and change that was led by government agencies. These merger types can be distinguished in terms of three distinct but closely related factors: the government's approach to consultation with stakeholders; the power dynamics and interaction between key stakeholders during both the consultation process and the post-merger restructuring process; and the extent of manipulation of any of those processes by government agencies.

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## **LIST OF ABBREVIATIONS**

AHA	Area Health Authority
AHCN	Academic Health Care Network
ALC	Alternate Level of Care
ASR	(Newcastle) Acute Services Review
BMA	British Medical Association
CCL	Canadian Congress of Labour
CEO	Chief Executive Officer
CHC	Community Health Council
CMH	Chedoke-McMaster Hospital
DGH	District General Hospital
DHA	District Health Authority
DHC	District Health Council
DOH	Department of Health
EMS	Emergency Medical Service
EPF	Established Programs Financing
FHSA	Family Health Service Authority
GDP	Gross Domestic Product
GNP	Gross National Product
GP	General Practitioner
HA	Health Authority
HATF	Health Action Task Force
HCH	Hamilton Civic Hospitals
HGH	Hexham General Hospital
HHSC	Hamilton Health Sciences Corporation
HIDS	Health Insurance and Diagnostics Services Act
HMC	Hospital(s) Medical Council

HR	Human Resources
HSR	Health Services Review
HSRC	Health Services Restructuring Commission
LOS	Length of Stay
MAC	Medical Advisory Council
MOH	Ministry of Health
MUMC	McMaster University Medical Centre
NCHT	Newcastle City Health NHS Trust
NGH	Newcastle General Hospital
NHS	National Health Service
NHSME	NHS Management Executive
NSR	Newcastle Strategic Review
OECD	Organisation for Economic Co-operation and Development
OMA	Ontario Medical Association
PFI	Private Finance Initiative
RHA	Regional Health Authority
RVI	Royal Victoria Infirmary
SJH	St. Joseph's Hospital
TLC	Trade and Labour Congress
UK	United Kingdom
VON	Victorian Order of Nurses
VP	Vice President
YHEC	York Health Economics Consortium

# CHAPTER 1

## INTRODUCTION

### 1.1 Background to this Thesis

In many countries in the 1990s, amid widespread concern about the rising costs of health care, governments and organisations involved in the delivery of health care services were under severe pressure critically to evaluate their existing systems and to find ways of containing costs without impairing the volume and quality of provision (Wolfe, 1991; Elola, 1996; Glennerster and Matsaganis, 1994; Church and Barker, 1998; Ferlie et al, 1996). In addition to the problem of rising costs, changing trends in health care practices, due to advances in medical technology and other factors, meant that needs for new and different treatments and methods of care were arising, and that existing acute care hospital facilities were often being used inappropriately and therefore inefficiently.

The British government and the provincial governments in Canada embarked on radical system-wide health care reform in an attempt to address this crisis. Hospital restructuring dominated the reform agenda. Hospital mergers became almost a panacea in the governments' thinking, and were assumed to be useful for several objectives, including reducing overhead costs, addressing management inefficiencies, achieving economies of scale and improving the quality of patient care. In Canada between 1990 and 1999 the number of hospitals declined from 1,231 to 929, a drop of almost 25 percent (though mergers were certainly not the only factor contributing to this change) (Canadian Healthcare Association, 2002). More than 30 major Canadian teaching hospitals merged into very large organisations in the 1990s (Canadian Health Services Research Foundation, 2000). In the same period, there were 40 mergers of NHS Trusts in England (Garside, 1999).

### 1.2 Aim of the Research

The aim of this research is to explore the dynamics of the interaction between key actors in the context of a merger of public sector teaching hospitals, and how these dynamics, as external and internal forces, operate to enable or constrain strategic change. The researcher defines key actors to include:

- (a) government agencies;
- (b) any review body appointed by or at the behest of the government to make recommendations for reform of the hospital services in question;
- (c) the hospital organisations involved in the merger;
- (d) medical professional groups within the hospitals;
- (e) the University medical school affected by the merger;
- (e) other hospitals and health services organisations within the community served by the merging hospitals; and
- (f) community organisations and local authorities.

All actors except government agencies and review bodies are referred to as 'stakeholders'. It is important to stress that in this research the term 'stakeholder' carries no connotation of stakeholder analysis, which is not used in this research (see Chapter 5, paragraph 5.2). Also, since the government only acts through its various agencies (such as Departments and Ministries), any references to 'government' should be construed accordingly.

The objectives of the research are:

- (a) to analyse the approach taken by government agencies and independent review bodies to the merger process;
- (b) to analyse the role of the stakeholders in the merger process, including both their interaction with the government and their interaction with each other;
- (c) to identify the key changes in the structure, systems and underlying values of the hospital organisations;
- (d) to develop a hospital merger typology, which identifies key merger characteristics and different pathways of change; and finally
- (e) to highlight the key issues arising, and lessons that can be learnt, from the cases studied.

To this end the researcher has conducted longitudinal case studies of two public sector teaching hospital mergers in the 1990s, one in Newcastle Upon Tyne, England and the other in Hamilton, Ontario, Canada.

The informants or interviewees selected for this research study will include government decision makers, senior executives, lead clinicians and middle managers.



The purpose of this sampling approach is to identify those people who are the most knowledgeable, have access to specific information about the merger due to their position in the organisation or community and who attended meetings which had a direct bearing on the outcome of the merger. The decision to use this sampling strategy is defined according to the parameters established by the research question and is further reinforced by the data collection process which drives informant selection through document analysis and interviewing.

### **1.3 Theoretical Framework**

The researcher will draw on the theory of ‘archetypes’ proposed by Hinings and Greenwood (1988, 1993, 1996) as a basis for understanding the dynamics of organisational change from a neo-institutional perspective. The cases provide a novel basis for testing out the value of archetype-based analysis. A significant part of the research underpinning those authors’ theory was based on studies of public sector organisations (specifically, British local authorities: Hinings and Greenwood 1993). However, whilst archetype theory recognises the influence of contextual forces on organisational change, it tends to concentrate attention on intraorganisational phenomena. As reflected in the stated aim of this thesis, the researcher wants to distribute attention more evenly between the contextual forces and the intraorganisational phenomena. This approach is particularly appropriate for research in the field of public sector health care organisations, for two reasons. First, in recent years there has been constant tension between the government and the health care community in both Britain and Canada. Second, there is a high level of interdependence between the various health care organisations serving any given geographical area. The researcher will therefore also draw on and evaluate Neil Fligstein’s (1990, 1998, 2001) work on the role of power and actors, as a potential framework for understanding the relationship between the actors in the field in which the organisation operates.

### **1.4 Cross-Case Comparisons**

International comparisons of health care reforms and hospital restructuring can offer an opportunity for governments and stakeholders in different countries to learn from each other’s experiences. Comparisons between cases can highlight similarities

and/or provide revealing contrasts. Sometimes meta-theories will emerge that can explain the differences between outcomes and process transitions from one event to another. The comparing of cases across countries may provide more theoretical and practical merit when it comes to exploring and accepting a wider range of possible explanations about the outcomes of both cases. McPhee (1995) stated that cross-case studies have diagnostic value because they can also reveal some underlying root causes of case differences that perhaps the researcher had not considered previously. Pettigrew (1990) found it was useful to integrate cross-case data by producing an explanatory typology, which he defined as a process map containing alternative paths of change leading to the end result.

Having worked for 20 years in the health care field including acute care hospitals in both Britain and Canada, the researcher was sceptical about hospital merger as a strategy to reduce health care spending and saw the potential advantage of comparing the hospital restructuring process in both countries with a focus on the inter-relationship between the key actors in that process.

## **1.5 Review of the Literature on Mergers**

The researcher found no studies on the interaction between the government and stakeholders in the context of hospital mergers. Those studies that are concerned with organisational change resulting from hospital mergers do not address the possible significance of this interaction; and none of the research concerning the interaction between the state and other actors (including stakeholders) relates specifically to hospital mergers.

A brief review of the merger literature is included below to provide an insight into the contextual difficulties that the key actors, and the emergent organisation, are likely to encounter in the course of the public sector hospital merger process.

### ***Mergers in General***

Mergers and acquisitions in the 1990s represented the fifth merger wave of the 21<sup>st</sup> century and their size and number suggests that the decade of the 1990s will be remembered for merger mania (Cartwright and Cooper, 1992; Hitt et al, 2001). The mergers of the 1990s differed from previous waves, not only in terms of increased

scale and geographical spread but also in terms of the type of combinations. Many of these mergers were classified as horizontal integration, which can be defined as a combination of two similar organisations in the same industry (Haspeslagh and Jemison, 1991). The merger wave of the 1980s was fuelled by the need to structure and focus on core and related businesses, while the merger wave of the 1990s was mostly the result of a desire to achieve economies of scale (operating efficiently at higher rather than lower levels of production) and scope (centralising multiple services to ensure critical linkages) and market power, in order to increase competitiveness in global markets.

In order to justify a merger in the public sector the magic words, as in the private sector, were 'economies of scale' and 'rationalisation'. But the evidence on economies of scale in the private sector is far from conclusive (Hitt et al, 2001; Haspeslagh and Jemison, 1991). There is no automatic reason why economies should emerge when two companies are brought together, as such economies come from integrated production. There may be possible advantages in large-scale operation, but this does not mean that large organisations, that are simply aggregations of formerly independent plants, can achieve them. Indeed research evidence has repeatedly demonstrated that mergers have had an unfavourable impact on profitability (Cartwright and Cooper, 1992; Hitt et al, 2001; Haspeslagh and Jemison, 1991; and Kitching, 1967) Instead of achieving projected economies of scale, mergers have become associated with lower productivity, worse strike records and higher absenteeism (Davy et al, 1988 and Cartwright and Cooper, 1992). It has been suggested that in the long term between 50-80 percent of all mergers and takeovers are financially unsuccessful and highly unstable (Haspeslagh and Jemison, 1991; British Institute of Management, 1986). Hunt (1988) supported these findings, stating that the success rates of mergers post-acquisition are in the region of only 50 percent.

Synergy is also not guaranteed in a merger. The possibility of such advantage may be there, but the success of the merger depends upon the management's ability to take advantage of opportunities (Beenstock, 1995). The key factor in determining success in the pre-merger stages is the quality of both the planning and the management of the change process itself (Hitt et al, 2001; Haspeslagh and Jemison, 1991). It seems that much of the research into post-merger performance emphasises the same factors.

Negotiation of a merger agreement consumes a considerable amount of managerial time and energy. Research suggests that once a potential acquisition target has been identified, it could be two years or longer before a bid is made (Hunt, 1988). The subsequent negotiations are likely to lengthen the process even further. It is not uncommon for negotiation to last several years. During this period, the acquiring organisation is likely to have become extremely well informed as to the financial health of the acquisition target, but to have learned little beyond that point (Haspeslagh and Jemison, 1991).

Most organisations are ill-prepared for the scale of problems that they invariably have to face. During the initial stage, expectations of stakeholders are often ambiguous, there are usually multiple motives offered and financial issues can be splintered off from broader organisational and strategic considerations. In the absence of any human merger audit, or carefully formulated human merger integration plan, most organisations muddle through the merger process, moving from one organisational crisis to another, rather than pro-actively managing people and anticipating problems. Most merger management is characterised by ad hoc reactive fire-fighting (Cartwright and Cooper, 1992).

The importance of organisational culture has often been over-estimated in the managerial literature (the work of Peters and Waterman (1982) is arguably an example of this). However, organisational and cultural issues are important if a successful merger is to be achieved and, as was observed by Peters and Waterman (1982), outstanding financial performance is often associated with a strong, dominant and coherent culture. This link finds an echo in the research of Hinings and Greenwood (1989), in which they argue that organisational structures and management systems obtain coherence and stability through their underlying values and beliefs or interpretive scheme. This does suggest that the type of culture of the combining organisation, the resultant cultural dynamics and the speed with which unitary and coherent culture emerges, play a critical role in determining the eventual outcome of the inter-organisational combination.

Existing work on mergers also shows that the merging of two organisations is complicated and requires the co-operation of many people. An uncooperative climate can lead to disastrous results whether during pre-merger negotiations or during post-

merger integration (Hitt et al, 2001). Resistance to mergers comes in a variety of forms and degrees of intensity. During a public sector merger, one form of resistance that may well be encountered is opposition by community stakeholders.

Generally, the overt power relationships between parties in a takeover are likely to differ from that between merging partners. In a takeover there is a clear perception of winners and losers. In such situations power is not usually regarded as negotiable, but is immediately surrendered to the new organisation on completion of the deal, at least by organisational elites. The takeover of another organisation is a visible symbol to employees and the community that the acquiring organisation is successful, while being acquired is likely to be construed as a symbol of failure at the organisational level and also, for some, the personal level (Cartwright and Cooper, 1992). In a hostile takeover there will probably be greater overt conflict and resistance to change if the dispute has mobilised the entire workforce. The distinction between friendly and hostile acquisitions lies in the attitudes of the stakeholders and the negotiating senior management (Haspeslagh and Jemison, 1991; Hunt, 1988).

The final integration stage in a merger or takeover is one of the most challenging aspects for management (Hitt et al, 2001). The integration process has been defined as an interactive and gradual process in which individuals from the two organisations learn to work together and co-operate in the transfer of strategic capabilities. Haspeslagh and Jemison (1991) describe this integration as a difficult and time-consuming exercise fraught with uncertainty and risks, where decisions are often made with incomplete and limited information, under pressure. Failure to move the company together quickly can destroy the value it hoped to achieve. Kitching (1967) concluded that the key to merger success is essentially the way in which the transition process is managed and the quality of the working relationships between the partnering organisations. His study found that in 81 percent of failed mergers, reporting relationships were said to be either unclear or frequently changed. Cartwright and Cooper (1992) identified two important factors for merger success: the cultural compatibility of the combining organisations and resultant cultural dynamics, and the way in which the integration process was managed.

Mergers and acquisitions differ from other processes of major organisational change in three aspects: the speed of change, the scale of change and the uncertainties of the

outcome for both parties. The integration process can take from 12 months to 7 years. Managerial relationships are well recognised as a major source of merger problems at any point in the merger process. Mergers are about power, differing perceptions of culture and how different stakeholders view the proposed organisational outcome (Hunt, 1988). Mergers are both a significant event for the organisation and its employees, and a major long-term process of change and integration.

The research on mergers in the private sector shows that they are not easy to implement successfully. The merger process in the public sector has the further disadvantage that it involves the state and multiple stakeholders with diverse sources of influence, and is therefore more easily politicised. This is especially so in the case of professional service organisations such as hospitals, where the long-established behaviour patterns of professionals, who have traditionally had considerable power and autonomy, may be disturbed by the merger (Denis et al, 1999).

### *Hospital Mergers*

Most of the recent literature on hospital mergers relates to research done in the U.S. The U.S. health care system differs significantly from the British and Canadian systems, so that generalising the results of the research is problematic. Whereas discussions of economies of scale and organisational factors are certainly relevant to all three systems, the U.S. system's concerns with questions of market share, prices and anti-trust laws is not easily transferable to the British and Canadian environments (although with the recent advent of NHS foundation trusts, similar concerns may begin to emerge in the British system).

Furthermore, most of the literature has tended to focus more on the results expected once the merger is consummated rather than on the merger process itself. In particular, the economic aspects of merger and the effect on the quality of patient care appear to have been the main concerns of the research.

It is interesting to note that the British Department of Health's guidance (NHS Executive, 1994) on the operation of the internal market in 1994 reviewed the literature on mergers relating to economies of scale and scope and to quality. It concluded that the evidence was at best mixed, that studies were subject to substantial

methodological problems, and that the evidence from the literature could not be used alone to justify decisions on reorganising services.

Markham and Lomas (1995) reviewed the literature on 'multi-hospital arrangements', varying from loosely-structured alliances to fully-fledged mergers, including Canadian examples. They examined the evidence for various types of benefits and disadvantages, classified into four areas: economic and financial, quality of services, human resources and organisational and managerial. Drawing on several case-study articles they concluded that the process adopted to implement the merger seems to be an important determinant of the balance between benefits and disadvantages, and that it may take up to ten years to achieve full integration.

In his article on teaching hospital mergers Andreopoulos (1997) argued that the principal difficulty consists in reconciling the research and teaching role with medical practice. The author discusses the dilemmas a teaching hospital has to face to preserve teaching and to meet economic constraints. Various modes of functioning after mergers are reviewed, from the maintenance of separate structures, which reduces the possibility of achieving economies of scale, to the elimination of duplication and expansion of the institution to an unmanageable size. The author suggests that some research laboratories could be reduced in size and their administrative support services bundled together. He also raises the question of the separation of clinical and academic activities, emphasising the advantages of co-operation instead of competition and the need for leadership in the integration of these activities.

Colón et al (1999) noted that the traditional rationale for U.S. hospital mergers, based on economies of scale, increased market power, and the ability to increase patient flow by providing a fully integrated service, does not take into account local conditions. They suggest that each case needs to be considered on its merits and provide a framework for assessing the potential for benefit from a merger based on two dimensions: structural attractiveness and organisational resistance. Structural attractiveness depends on the how close the hospitals are, their relative size and the dominance of managed care. For example, economies of scale are possible for sizes of up to 300-400 beds but there may be diseconomies beyond that. Even when structural factors are favourable, organisational resistance can prevent the realisation

of benefits. The authors cite physician relations, the integration of assets and leadership, and the pressures for improved performance as factors that may assist or hinder merger implementation. In particular, problems can arise in reconciling physicians' interests with those of the new institution. To facilitate change, it also appears desirable to replace board members with people who have no affiliation with the old institutions.

Similarly with regard to economies of scale, Posnett (1999) noted that studies in many countries have shown that the best size for acute hospitals is actually between 200 and 400 beds; above that, management and administration costs tend to increase.

A Canadian study by Denis et al (1999) provides a useful insight into the particular problems encountered in mergers of public sector hospitals with different cultural profiles. The authors described the processes of implementation of two major teaching-hospital mergers (of three hospitals each) in Quebec beginning with the negotiations leading to the merger agreement and tracing the early phases of implementation for approximately two years. It is important to note that in both cases the merger was imposed by the government, as part of Quebec's 1992 health reform.

In one of the cases, relations between the three nominated hospitals were so highly conflictual that a special committee was put in place by the Ministry of Health and Social Services to secure agreement among them. In the other case, there was resistance to the merger but an implementation committee was formed by the leaders of the three hospitals, avoiding the need for further intervention by the Ministry. The subsequent processes, as presented by the authors, of leadership development, strategic framing and operationalisation followed very different paths, yet in both cases the new organisation experienced difficulties in getting operations underway successfully. The authors concluded that limited resources, diffuse power and divergent cultures were largely responsible for the difficulties experienced. They also argued that a 'bottom-up' process that ensures active participation of professionals in decisions that concern them is clearly essential; yet if the mergers were to make any economic sense, the process must also incorporate some legitimate means of breaking deadlock, evaluating alternative projects, and constructing a form of global rationality. This may have to come from the 'top-down.' An effective process must somehow balance both.



In a cross sectional study of nine NHS Trusts in Britain, Fulop et al (2002) found that Trusts' larger sizes after mergers had unintended negative consequences, as well as predicted advantages. The tendency for one trust's management team to dominate over the other resulted in tension. Difficulties in the merger process included perceived differences in organisational culture and perceptions of 'takeover' which limited sharing of 'good practice' across newly merged organisations.

In March 2000 a major two-day conference was held on hospital mergers in Canada in the 1990s, for members of the Association of Canadian Teaching Hospitals. No less than 24 CEOs of Canadian teaching hospitals, all of whom had been involved in mergers, spoke at this conference. The practical experiences emerging from the proceedings were as follows.

- (a) There had not been nearly enough research or even sharing of information across the country on hospital mergers.
- (b) Corporate culture is a real issue in hospital amalgamations. The loss of that culture is what people mourn in a merger and lack of a common culture can keep a new organisation from succeeding.
- (c) A new culture cannot begin to develop until workers and professionals from the different institutions start working together. Although all employees suffer destabilisation in a merger, physicians are the most important group in the integration of cultures.
- (d) Even the best-planned mergers can be stymied by the vicissitudes of government behaviour. Too often, fear of political repercussions or the loss of political will in the face of an impending election can undermine years of work, while a change of government or political interference can derail even mergers that seem to be well on track.
- (e) The elaborate schemes worked out in many mergers to combine boards (usually a set number of seats apportioned to representatives of each of the former hospital boards) had not served amalgamations well. In an effort to represent all the involved parties, they are often too big to function smoothly, and many trustees cling to old loyalties as though they are there to protect the interests of their old organisation, rather than governing a new one.
- (f) The consensus at the conference was that a fresh group of volunteers, ready to back the actions of a CEO who comes from outside any of the amalgamating hospitals, can do much to make a merger work.

(g) However, thorough negotiations and careful planning, hospitals do not spring fully-formed from merger agreements. The real restructuring comes about through a series of micromergers: the incremental melding of departments and programs within merged hospitals that happens after the formal amalgamation is made official.

(h) It was generally agreed that micromergers need very careful management, but in too many cases have been left to manage themselves in the wake of an amalgamation.

(i) In the case of Edmonton's health services, for example, amalgamation worked because those negotiations were done by mixed teams of staff from different disciplines and different sites working together to plan the micromergers of each department or program. Decisions were made by consensus and if a team could not reach consensus, it lost the right to make the decision (Canadian Health Services Research Foundation, 2000)

It can be seen that although the conference noted the vicissitudes of government behaviour and political interference as potential problems for hospital mergers, it did not address the interaction between government and stakeholders. Further, the conference highlighted the need for leaders and staff in merging hospitals to actually start working together to both build a new culture and effect the real restructuring; but it did not consider the interaction of the hospitals (and other community stakeholders) during the review and consultation process before amalgamation .

## **1.6 Relevance of this Research**

In terms of hospital merger activity, the health systems in Britain and Canada have experienced relative calm in the five years that have passed since the merger mania decade of the 1990s. However, there is among health professionals and academics in Canada a sense of the inevitability of another policy cycle of mergers (Canadian Health Services Research Foundation 2000). In Britain, respected academics have attacked politicians' 'wheezes' and 'smokescreens' in relation to health service reconfigurations, and their use of mergers as:

'crude methods for disciplining obdurate clinicians, and weak managers who fail to control NHS resources efficiently.' (Sheldon and Maynard, 1999:1762)

A clear indication that further hospital merger activity is to be anticipated in Britain is to be found in recent legislation. In the National Health Service and Community Care

Act 1990, which implemented the internal market reforms, there was not one reference to mergers. In sharp contrast, the Health and Social Care (Community Health and Standards) Act 2003 contains specific provisions (sections 28 and 29) enabling an NHS foundation trust to merge with another trust (subject to regulator approval and public consultation). It may well be that the establishment of the Independent Regulator, and new financial freedoms for those organisations that become NHS foundation trusts, will give rise to merger process dynamics somewhat different from those experienced by stakeholders previously. Ultimately however, the fundamental dynamic will not change: stakeholders will only be able to proceed with a voluntary merger, or avoid involuntary restructuring, through interaction with an actor (regulator) appointed and empowered by the government.

Research done on government and stakeholder interaction in public sector hospital mergers may also be useful to inform, and/or provide comparisons with, studies of restructuring of other public sector services, such as education. It is relevant to note that in Britain, from 1993 (when colleges became independent from local authority control) to 2003, 37 colleges had been involved in mergers, either with other colleges or with higher education institutions (Centre for Education and Industry, University of Warwick Research Report No. 459).

As can be seen from the preceding review of published work on mergers, the interaction between government and other actors in public sector hospital mergers has not received the specific attention of scholars to date. An important feature of this research is that it looks closely at the behaviour of the government in each of the two cases and does so from an entirely independent perspective. All costs associated with this research were borne by the researcher personally, with no funding assistance from any governmental or other body. It may be that commissioned research opens up possibilities for direct access to actors and organisational environments that are of interest but might not otherwise be available. In this case however the researcher had no difficulty in gaining such access independently (for further information in this regard see Chapter 3). It can be argued that scholarly research should seek to solve contemporary problems identified by those who are experiencing the problems; but identification of the problem area and independence and impartiality in its study are separate issues. Scholars can themselves (i.e. independently) identify, and arguably

anticipate, those problems through their knowledge of developments in the relevant field.

While acknowledging that some research may only be possible through commissioning, the researcher believes that commissioning gives rise to three obvious and significant concerns. First, the researcher is required to study areas (or problems) identified as of relevance and interest by someone else (the commissioner) who may not have an interest in contributing to theoretical development. Second, the commissioner/funder, or even the organisation/actors studied, may exercise inappropriate editorial control over the published research report. Third, being dependent upon funding for the current and possibly future projects, the commissioned researcher may shy away from expressing clearly any observations likely to cause controversy or embarrassment to the funder or organisation studied.

## **1.7 Structure of the Thesis**

Chapter 2 provides an overview of the development of archetype theory, which the researcher will apply in the study of hospital mergers. The strengths and weaknesses of archetype theory are discussed and critiqued, and it is argued that archetype theory has a significant limitation in relation to interaction between organisations, in that its focus is on intra-organisational dynamics. In this research therefore archetype theory is applied in combination with concepts derived from the work of Neil Fligstein exploring the importance of power and the role of actors (including the state) and social skill with regard to change and stability within organisational fields. This approach will facilitate a more comprehensive analysis of public sector hospital mergers.

Chapter 3 on research methods considers the strengths and weaknesses of case study methodology and addresses how this approach allows the researcher the flexibility to track the change process and collect longitudinal data in real time and retrospectively. The chapter describes the case selection criteria and provides details of the fieldwork undertaken in England and Ontario. The research design, data collection and cross case analysis is outlined.

When comparing the hospital merger processes in England and Ontario, it is important to highlight the similarities and differences between the two healthcare systems. Chapter 4 compares and analyses the two health care systems in terms of basic principles and service objectives, provision of service, the structure of the health care service, the role of the government and their respective funding systems. The discussion of each country's health service reform and restructuring agenda sets the backdrop for the merger cases.

The English and Ontario case studies are presented in Chapters 5 and 6 respectively. Each case study discusses the government reform agenda and how the government proposes to restructure acute care hospital services as part of a system-wide change strategy. Key events are identified and discussed in relation to their impact on the merger process. The role and social skill of actors, including government agencies, and the dynamics of their interactions is explored and, in Chapter 7, compared across cases. The pressure of government reform and the implementation of organisational restructuring is considered in terms of whether or not a new hospital archetype emerges. The theoretical framework used in these case studies stems from Greenwood and Hinings' work on archetype theory and the work done by Neil Fligstein on the role of actors and use of power and social skill to induce co-operation with other actors in the field.

The cases are compared and the main findings of the research are discussed in Chapter 7. A merger typology is developed which highlights the relationship between the research findings and the combined theoretical constructs applied in Chapters 5 and 6.

The conclusions of the research are presented in Chapter 8. The key findings are discussed in relation to the aim of the study. The usefulness of archetype theory and Fligstein's work, separately and in combination, is evaluated. Future areas for research are identified.

In relation to the hospital organisations studied in this research the term 'merger' is used in a wide sense, to include not only the amalgamation of distinct legal entities (hospital organisations) but also the acquisition of by one organisation of all or most of the hospital services of another organisation. The expression 'pre-merger phase' refers to the review, negotiation and consultation processes leading to the *decision* to

merge; and 'post-merger phase' refers to the processes of organisational restructuring and service integration following this decision. The 'merger process' includes both of these phases.

## CHAPTER 2

### A THEORETICAL FRAMEWORK FOR ANALYSING ORGANISATIONAL CHANGE: ARCHETYPES, POWER AND SOCIAL SKILL

#### 2.1 Introduction

This chapter sets out the theoretical framework chosen for the research presented in the thesis. This framework consists of neo-institutionalist concepts of transitions between particular or hybrid 'design archetypes', integrated with political-cultural perspectives on the use of power and social skill by strategic actors. Using this framework for analysis, the researcher will seek to elucidate the change processes that emerged in the cases and the reasons for the striking difference between them.

Organisational theorists have had great difficulty finding a generic classification scheme for organisations and organisational changes (Scott, 1998). There is a diversity of organisation theory perspectives and research designs, and no general scheme has won approval from the community of scholars (Aldrich, 1999). What attracted the researcher to the institutional perspective generally is that it has a 'broad reach.... making it potentially relevant to all levels of analysis and all spans of time, from micro-level interactions to large-scale change in nation-states.' (Aldrich, 1999:52). The strength of new institutional theory is its capability to explain how organisations are connected with their institutional surroundings (Beckert, 1999).

Archetype theory (as developed by its leading proponents Ranson et al., 1980; Walsh et al., 1981; Greenwood and Hinings, 1988, 1993, 1996; Cooper et al., 1996; Brock et al., 1999) suggests that change within organisations is best understood through the inclusive analysis of overall patterns of relationships, rather than through the consideration of the behaviour of particular groups and their interactions. When, as here, the aim is to study the transition of organisation forms as wholes, the approach has the virtue of attempting to conceptualise organisational phenomena at the appropriate level. Such a holistic perspective is an obvious advantage if the subject in hand is the longer term transition of organisational structures and forms. The

archetype approach allows a clear perception of the emergent properties of organisations, and so makes possible a perception of how effectively an organisation is functioning. It is also proposed that using this approach it is possible to be able to gauge the scale of change. The concept of ‘organisational tracks’ is used in this study to indicate that in research process the investigator maps what happens to the organisation in total and also assesses both the pace and sequence of change.

Archetype theory has been applied in several studies of change in the public health sector in both the UK (Ashburner et al., 1996; Kitchener and Whipp, 1997; Kitchener, 1998, 1999; Mueller et al., 2003; McNulty and Ferlie, 2004; Dent, 2005) and in Canada (Denis et al, 1996, 2001; Reay and Hinings, 2005). Some scholars have however argued that archetype theory tends to reify the organisation and belittles the role of human agency and too readily makes general assumptions about professional organisation and change, especially in the context of public services. In this study, however, it is continuously borne in mind that institutions only ever act through their agents. In this respect, Neil Fligstein’s more recent work (Fligstein, 1997, 1998, 2001) focusing on institutional entrepreneurship and the social skill of individual and group (collective) actors is particularly helpful. Fligstein is also well known for his earlier work (Fligstein, 1985, 1987, 1990, 1996) at, or more towards, the macro level of organisational analysis, but it is important to appreciate that his more recent work, which he describes as a ‘political-cultural perspective’, focuses directly on actors: in particular on the role of power, where it derives from and how key actors use it.

The researcher will therefore argue that her chosen theoretical framework overcomes the perceived ‘human agency’ problem, and also explicates the variable role and influence of professionals in organisational change. The combination of institutional and political-cultural perspectives is supported by DiMaggio’s view that:

‘once institutional and political models are regarded as complementary tools for understanding different aspects of institutional phenomena ... the range of problems to which institutional insights are relevant is likely to broaden’ (DiMaggio, 1988:7)

The researcher begins by reviewing the theory of structure underlying archetype theory and how this improves upon contingency theory in regard to recognition of the role of human agency. An argument that archetype theory retains some legacy of



functionalism is then considered; this leads into a discussion of archetype's perspective on the dynamics of organisational change, which re-conceptualises organisational change as institutional change. Particular attention is given to the increasingly important concept of sedimented or hybrid archetypes, and to the suggestion made by some scholars that archetype theory generalises uncritically across professions. In this research hospitals are viewed as being part of an organisational field and this concept is briefly considered. This leads to a discussion of the new institutionalist perspective on organisational change and how various authors have attempted to solve the problem of 'embedded agency'. The researcher then explains her use of a combination of archetype theory and Fligstein's political-cultural perspective as the theoretical framework for this research, leading in to a detailed discussion of the latter.

## **2.2 Organisational Structure in Archetype Theory**

The foundations of archetype theory are to be found in the works of Ranson et al. (1980) and (to select but one of several works in the same vein by the theory's most active proponents) Greenwood and Hinings (1988). The development of the theory has also been significantly influenced by the work of Miller and Friesen (1980, 1984) relating to configurational theory. The initial concern of the theory, as appears from Ranson et al.(1980) was with structure. Greenwood and Hinings (1988) sought to expand the theory to cover change and stability in organisations, using the concept of archetypes of organising and organisational tracks of change. In this section the theory of structure and of archetypes is set out. Subsequent sections of this Chapter deal with the tracks of change and the subsequent further developments of the theory which also focus on organisational change.

### ***A Theory of Organisational Structuring***

#### *Framework and Interaction*

Ranson et al. (1980) elaborate a theoretical model designed to illuminate the social mechanisms that determine the process of organisational structuring and shape the ensuing structural forms. They seek to overcome the dichotomy within

organisational studies between the 'structural' perspectives of traditional bureaucratic theories and the 'interactionist' stress on informal organisational structures emerging from what people actually do. Explicitly drawing on the works of Giddens (1976, 1977) and Bourdieu (1971, 1977, 1979), they suggest:

'The unhelpful contrasting of framework and interaction can be overcome by conceiving of structure as a complex medium of control which is continually produced and recreated in interaction and yet shapes that interaction: structures are constituted and constitutive. This suggests a way of connecting framework and interaction as mutually embodying common categories, a way of seeing structures as a vehicle constructed to reflect and facilitate meanings. Structural frameworks systematically embody normative expectations and prescriptions for competent operation and satisfactory performance' (1980:3).

### *Provinces of Meaning and Power*

Ranson et al. (1980) argue that 'structuring' of organisations is typically the privilege of powerful actors, who are able to shape organisations to their own purposes. These purposes stem from 'provinces of meaning', comprising two intersubjective forms: on the one hand, interpretive schemes that enable actors to constitute and understand their organisational worlds as meaningful, and on the other hand, the intermittent articulation of elements of interpretive schemes as purposive values and interests. Among organisational members, conflict is as common as consensus. Citing the work of Gouldner and Perrow, they argue (1980:7):

'An organisation is thus better conceived as being composed of a number of groups divided by alternative conceptions, value preferences, and sectional interests. The analytical focus then becomes the relations of power which enable some organisational members to constitute and recreate organisational structures according to their provinces of meaning...'

Walsh et al. (1981), in developing Ranson et al.'s (1980) argument, further elaborate the role that power and interests can play in maintaining, as well as changing, the structure of an organisation. They argue that organisation design types establish a particular distribution of resources and power that in turn buttresses the coherence of that design. This concept of power deals with one of the major criticisms of contingency theory, namely that it did not take into account the political realities of organisations (cf. Donaldson, 2001; Mintzberg, 1983). There began to emerge more recognition of the need to see organisations as social systems, which included cultural

aspects and political issues. Thus analysis shifted to make much more central the power resources possessed by different groups in the organisation and the way in which they would use these resources to shape their own agendas and, through these, change the organisational structure. Quantitative methodology was also criticised and it was argued that much of the empirical evidence, which would support values and conflict between groups, was better collected through qualitative methods (Pettigrew et al., 1994).

### *Agency*

From Ranson et al.'s (1980) perspective agency is - even in the case of powerful actors - constrained by contextual constraints, with organisational members differentially responding to and enacting their contextual conditions according to the opportunities provided by infrastructure and time. Such constraints are inherent in characteristics of the organisation itself (scale of operation, mode of technical production, and resources) and in the characteristics of the environment, particularly the socio-economic infrastructure into which an organisation is locked and the institutionalised environment in which organisations live. The authors adopt the Weberian notion that the source of legitimation for an organization's structural arrangements and processes lies in its institutional environment and, following Meyer and Rowan (1977:343) argue that in order to understand why organizational decision makers adopt certain policies, procedures, and occupational specialisms, we must look to their institutional reinforcement: 'such elements of formal structure are manifestations of powerful institutional rules which function as highly rationalized myths that are binding upon particular organizations.' Ranson et al. recognise that 'all organisations are located within a broader social structure' (1980:10). They argue that the influence of contextual constraints upon organizational structuring can be quite independent of an individual actor's perception of them; for example, the contraction in financial resources to local authorities in England and the impact of demographic decline upon school rolls were not dependent upon (enacted by) perceptual processes but nevertheless had significant repercussions for structural arrangements. Thus, a distinction needs to be made 'between contextual pressures which have an effect upon structuring

because of the ways they are perceived, and those that have an impact in spite of perception' (1980:11).

## ***Defining Archetypes***

### *Classification of Design Types*

Greenwood and Hinings (1993:1052) define archetypes in terms of Ranson et al.'s (1980) theory of structure and Miller and Friesen's (1984) idea of patterns, as follows:

'... patterns are a function of the ideas, beliefs, and values - the components of an 'interpretive scheme' (Ranson, Hinings, & Greenwood, 1980) - that underpin and are embodied in organisational structures and systems. An archetype is thus a set of structures and systems that reflects a single interpretive scheme'.

More concisely, and recognising patterns as constituting coherence and common orientation, Hinings and Greenwood (1988:4) define archetypes as:

'... compositions of structures and (management) systems given coherence and orientation by an underlying set of values and beliefs'.

A key point here for the purposes of this research is that archetype theory's concept of 'coherence' is used for *classifying* design types, not for explaining how they are born or change. According to Greenwood and Hinings (1988:299) (researcher's emphasis):

'The notion of coherence between these beliefs and values, on the one hand, and structural arrangements and processes on the other, provides a basis for the *delineation* of organisational design archetypes.'

## ***Distinguishing between Archetype and Contingency Theories***

The idea of an archetype is founded on both the foregoing theory of organisational structure and the notion, usually associated with the work of Miller and Friesen (1984), that organisations operate with a limited number of configurations of structure, strategy and environment, so that such configurations (rather than separate organisational elements) should be the focus of analysis:

‘configurations are composed of tightly interdependent and mutually supportive elements such that the importance of each element can best be understood by making reference to the whole configuration.’ (Miller and Friesen 1984:1)

The gist of Miller and Friesen’s (1984) argument is that organisational designs should be considered in terms of the patterning, or coherence, of component elements because the structural attributes and processes of an organisation frequently have a *coherence* or common *orientation*, and thus form an archetype.

The ‘holistic’ approach of archetype and configurational theories contrasts with mainstream contingency theory to the extent that the latter has a reductionist tendency to measure linear relationships between limited sets of structural and environmental variables, and so ‘may be missing other important conditions that affect relationships among environmental and structural variables’ (Miller and Friesen, 1980:269). More specifically, the prevalent econometric methodology used in contingency theory, by attempting to isolate the effects of each contingent variable, downplays complex forms of interaction and ignores non-linear relationships (Meyer et al., 1993). Contingency theory holds that a particular organisational form (for example, the divisionalised form) will be appropriate, with regard to task efficiency, to particular combinations of scale, product diversity, product market, geography and process (Donaldson, 1985). Miller and Friesen (1984) and Mintzberg (1979) suggest that it is the occurrence of relationships between structure, strategy and environment that forms the basis for establishing organisational coherence. Greenwood and Hinings (1988:297) point out that ‘in this, they are following the general thrust of contingency theory’. By contrast, archetype theory, whilst adopting configurational theory’s broader focus on organisational variables, does not view coherence as resulting from relationships between structure, strategy *and the environment*, but from the relationships between an organisation’s prevailing interpretive scheme and its structure and systems. In organisational studies the nature of the environment in which an organisation is placed is usually ‘conceptualised as something to be adapted to or controlled’ (Greenwood and Hinings 1988:298). In this respect archetype theory goes some way towards accommodating strategic choice theorists’ criticism of contingency theory. They considered that contingency theory had overstated the degree of determinism that it is possible to show. Structure may be shaped by contingencies,

but what is required has to be translated into actions by particular groups: thus it was necessary to explore the impact of strategic choice (Child, 1972). The strategic choice view argued that the influence of contingency on structure was mediated by human actors. Moreover, structure could affect contingency in that changing the contingency would not only rectify a misfit between structure and contingency, but also take the organisation in new directions, not previously envisaged. In bringing the human actor back into organisational theory, Ranson et al., like the choice theorists, brought back in the factors that directly shape human choice, such as ideas and interests; they moved away from explanation by objective, material factors and emphasised instead subjective factors such as ideas, perceptions, beliefs, values and ideologies.

### *Issues Concerning Structure in Archetype Theory*

It is evident from the foregoing discussion that archetype theory can be regarded as a distinct improvement on contingency theory. In particular, it recognises and accommodates the role of groups of agents, the problems that organisational conflict may introduce and the difficulties of achieving effective organisational change. However, it has been argued by Kirkpatrick and Ackroyd (2003) that archetype theory retains a significant commitment to a basically functionalist explanation of organisational structures. This, they argue, is because although archetype theory recognises the existence of conflict within organisations, conflict 'is thought of as necessary only insofar as it is part of the mechanism by which organisations are brought into a better alignment with their environments' (2003:738). From this they conclude that (2003:738):

'....there is no recognition in archetype theory that, because of differences in outlook and policy between groups, political instability (or lack of coherence) is an 'in built' or normal feature of organisations'

Similarly, the authors argue that although archetype theory attempts to analyse processes of interaction within organisational fields, 'these are seen as being important only insofar as they facilitate movement between archetypes that are judged to be 'functional' in new contexts' (2003:738).

To address this issue (and another issue relating to archetype theory's perspective on professional organisation and change, especially in the context of public services) the

researcher will consider how archetype theory perceives the dynamics of organisational change in the context of institutions. The influence of institutional theory has always been apparent in the development of archetype theory (see for example the reference to ‘normative expectations and prescriptions’ in the quotation from Ranson et al. (1980:3) above). The more recent work of Greenwood and Hinings (1996) confirms archetype theory’s ‘reconceptualisation of organisational change as institutional change’ (Weick and Quinn, 1999:364).

### **2.3 Dynamics of Change in Archetype Theory**

#### *Archetypes as Institutionally Derived Templates*

The archetype perspective embodies an increasing focus on the institutional origins of archetypal templates and on the complexity of political, regulatory and technical changes faced by organisations; the theory explains the response of individual organisations to pressures in the institutional field as a function of an organisation’s internal dynamics (Greenwood and Hinings, 1996). It is immediately apparent that archetype theory is here focusing on intra-organisational dynamics, rather than on interaction within the institutional sphere (or organisational field) or within wider social arenas. The researcher has been mindful of this limitation in formulating her theoretical framework.

#### *Competing Interpretive Schemes*

Archetype theory as originally propounded suggests that organisational coherence will not be achieved unless organisational structures and systems are underpinned by a *single* interpretive scheme (Greenwood and Hinings, 1993). Mention has already been made of contemporary archetype theory’s recognition that differing sets of values, ideas and practices may co-exist in a ‘sedimented’ fashion. However, even where only one underlying interpretive scheme is identified in a given scenario, it is not necessary that all of the current organisation members be committed to it (Greenwood and Hinings, 1988); such commitment is not a definitional component of an archetype. In fact, the pattern of commitments to one or more interpretive schemes is seen as a ‘potential dynamic of change’ (Greenwood and Hinings

1993:1057). An archetype is identified 'not by measuring the ideas, beliefs, and values of organisation members, but by comparing the pattern of the organisation's structures and systems, as revealed by empirical investigation, to the pattern of a 'previously identified *ideal template*' (Greenwood and Hinings, 1993:1069). The search for such ideal templates should start within an institutional sphere or industrial sector, because it is there that institutional prescriptions and proscriptions (Hinings and Greenwood, 1988b), or 'strategic recipes' (Child and Smith, 1987) will be found (Greenwood and Hinings, 1993). The institutionalist notion that organisations conform to sectoral rules and requirements for reasons of legitimacy and resource flows (Meyer and Rowan, 1977; DiMaggio and Powell, 1983; Tolbert and Zucker, 1983) suggests that:

'institutionalised belief systems constitute a distinctive class of elements that can account for the existence and/or elaboration of organisational structure' (Scott, 1987: 497).

Thus, Greenwood and Hinings (1993) argue that analysis is required at two levels. The first is the institutional sector, where the research task is to discover which organisational forms are legitimated: these legitimated forms are the archetype templates. The second level is that of individual organisations, where the research task is to examine the extent to which those organisations do or do not approximate their sector's archetype or archetypes.

### *The Institutional Origins of Archetypes*

Institutional theory posits that regularised organisational behaviours are shaped by ideas, values, and beliefs that originate in the institutional context (Meyer and Rowan, 1977; Zucker, 1983). Organisations conform to contextual expectations of appropriate organisational forms to gain legitimacy and increase their probability of survival, even though these expectations may have little or no bearing on technical performance (DiMaggio and Powell, 1991; Scott, 1987). Institutionalists thus see organisational behaviours as responses not solely to market pressures, but also to institutional pressures: for example, pressures from regulatory agencies, such as the state and the professions, and pressures from general social expectations and the actions of leading organisations (Greenwood and Hinings, 1996). These pressures lead organisations in the same institutional sector to adopt the same organisational form; that is, the



institutional context provides ‘templates for organising’ (DiMaggio and Powell, 1991:27). Greenwood and Hinings (1996) argue that the concept of archetypes provides a robust definition of radical and convergent change: the former occurring when an organisation moves from one archetypal template-in-use to another, the latter occurring within the parameters of an existing template. They note that using ideas, beliefs, and values as the basis for identifying templates of structures and systems is not unique to institutional theory; but that the institutionalist perspective differs from others because it stresses ideational templates as originating outside of the organisation and being relevant to a population of organisations within an organisational field. So, institutional theory draws attention to institutionally derived and created templates of organising to which organisations converge, rather than to the uniqueness of individual organisational cultures.

### *Inertia*

A template rationale for an individual organisation may not be rational for large numbers of organisations (DiMaggio and Powell, 1983; Fligstein, 1985). There is, in other words, a normative tone to institutional discussions (Meyer and Rowan, 1977; Zucker, 1977; Oliver, 1991). Consequently, institutional theorists stress the stability of organisational arrangements and the characteristic of inertia rather than change (Tolbert and Zucker, 1983; Tolbert, 1985). The prevailing nature of change is seen by institutionalists as one of constant reproduction and reinforcement of existing modes of thought and organisation; that is, change is convergent change (Greenwood and Hinings, 1996). Thus, by emphasising archetypes/templates that originate in the institutional context and around which networks of organisations converge, institutional theorists suggest a likely dynamic of inertia. Radical change is thus problematic because of the normative embeddedness of an organisation within its institutional context (Baum and Oliver, 1991). Moreover, the greater the extent to which organisations are tightly coupled to a prevailing archetypal template within a highly structured field, the greater the degree of instability in the face of external shocks (Powell and DiMaggio, 1991). Thus, the greater the normative embeddedness of an organisation within the institutional context, the greater the likelihood that when change does occur it will be revolutionary rather than evolutionary: that is, the pace of

upheaval will be fast, not gradual, and the scale large, not modest. (Greenwood and Hinings, 1996).

### ***Disturbances and Organisational Tracks of Change***

#### *Disturbances*

Organisations' tendency to orientate to 'inertia' rather than change is not an exclusively institutionalist concept, and indeed is a common theme in organisational theory (Miller and Friesen, 1984). However, when something or someone sparks the change process by creating some form of disturbance, the disturbance will 'track' its way through the organisation (Greenwood and Hinings, 1988:294). Of all the roles that the design archetype plays one of key importance is the steering of disturbances through the organisation. The track followed is not some predetermined activity but is descriptive of developments over time. The nature of the initial action/response and subsequent actions will be related to the structuring and systems of the design archetype and this will influence the track that the disturbance will follow; analysing the workings of the design archetype therefore provides a key to understanding organisational change (Laughlin, 1991).

#### *Tracks of Organisational Change*

The use of organisational tracks is an attempt to provide a systematic framework, involving the mapping of movements or sequential events as organisations attempted to move between archetypes. A movement *away* from an archetype involves the *decoupling* of structures and systems from a previous prevailing interpretive scheme. Movement *into* a new archetype involves the *recoupling* of structures and systems to a new set of ideas, beliefs and values (Hinings and Greenwood, 1988; Greenwood et al., 1996). Tracks are about the configuration of interpretive decoupling and recoupling and whether there was any loss of design coherence and any displacement of underpinning interpretive schemes over time. The purpose of looking at configurations of interpretive decoupling is to observe whether organisations do or do not move between archetypes and at what pace.

## *Configurations of Interpretive Decoupling*

When an organisation undergoes major transformational change, the pathway or track of change will not be a linear progression moving from one organisational design type to another. The process of change involves a pattern of cultural and structural detachment. As the organisation moves along this continuum of change between the two archetype designs, there will be various non-coherent positions of change along the way. Hinings and Greenwood (1988) develop four prototypical tracks: inertia, aborted excursions, reorientations (transformations) and unresolved excursions.

### *Inertia Track*

In this track, organisations gravitate towards a design archetype and remain there for a lengthy period. Structural arrangements develop a consistency and coherence that is given meaning by a common interpretive scheme. Any changes that take place would still conform to the prevailing meanings, and be elaborations of the same basic design. The organisation would demonstrate consistent and sustained attachment to one interpretive scheme. Therefore it could be said that, over time, inertia exists. This track involves one design archetype.

### *Aborted Excursions*

This second track involves a temporary deviation of the initial structural design of the organisation. One or more part(s) of the structure or systems would become decoupled from the prevailing interpretive scheme. If the organisation were to experiment with a new structure, which proved to weaken internal coherence and produced declining performance, this embryonic archetype might be aborted. The organisation would probably return to the original archetype. This track would be called the aborted or discontinued excursion.

### *Reorientations or Transformations*

When an organisation leaves one archetype design and moves to another, a design transformation occurs. In this situation the prevailing values and ideas would lose legitimacy and an alternative interpretive scheme, carrying a different pattern of

structural arrangements, would emerge. The organisational structures become decoupled from the old legitimating interpretive scheme, and recoupled to a new one. A new design archetype is established. This would rarely be a smooth process and transition from archetype to another along this track could take several forms such as temporary reversals, long delays and incompatible and conflicting structures and values, which could force the organisation into a schizoid position.

### *Unresolved Excursions*

All the previously mentioned tracks work on the assumption that the archetype moved toward structural and processual coherence. But there could be situations where the organisation became locked between the pulls of competing interpretive schemes articulated within the organisation. The failure to obtain coherence would mean that the organisation would actively move away from its coherent archetype but be unable to complete the change process. This track represents failed or resisted attempts at reorientation.

### ***Transformational Change: Process Mapping in Archetype Theory***

The analysis of transformational change suggests that it is a complex process. Hinings and Greenwood (1988) consider it important to develop an organisational biography/history through process mapping which would allow the pace and linearity of change, and the sequence of events, to be analysed.

### *Pace of Change*

The pace of change focuses upon the speed at which transformations occur: whether radical change occurs incrementally over a period of time, or is revolutionary and concentrated within a short time period, affecting virtually all parts of the organisation simultaneously (Greenwood and Hinings, 1996). According to Hinings and Greenwood (1988), the pace of change can influence the success of a reorientation track; successful reorientations usually follow a significant and considerable change effort, which establishes a sustainable momentum. The pace of change is an

important aspect of merger, and a much-debated area regarding merger success (Samuels, 1971).

### *Linearity of Change*

The linearity of change focuses on the extent of directional consistency. There may be a cumulative momentum from one archetype to another. Alternatively the organisation may be pulled between competing interests, with the result that the change process will be characterised by disjunctions, oscillations and temporary reversals or delays in the overall movement toward a different archetype (Hinings and Greenwood, 1988).

### *Sequence of Events*

Another important aspect of understanding the tracking process of decoupling from one interpretive scheme to another is the analysis of the sequence of events. The possible sequences that might exist in the various tracks cannot be anticipated, and their mapping has to be a matter of empirical observation and analysis. The sequence of change depends on the dynamics of interpretive decoupling and recoupling and of prescribed restructuring and emergent practices. A movement away from an archetype involves the total or partial decoupling of structures and systems from a previously prevailing interpretive scheme. Movement into a new archetype involves the re-coupling of structures and systems to a new set of values, beliefs and ideas. The initial effort at reorientation is often at the *emergent* level, and is consolidated by *prescribed* arrangements (Hinings and Greenwood, 1988). Its success may depend on the emphasis given to the transformation of certain elements of the organisational structures and systems, the relative importance of which can vary across organisations. Successful reorientations tend to have an early focus on 'high impact' systems, i.e. those that particularly mark the difference between the old and the new archetypes, such as the appointment of a new senior management team (Kanter, 1983).

## *Understanding the Dynamics of Change in Archetype Theory*

Hinings and Greenwood (1988) emphasise three concepts as being important for understanding the dynamics of change. First, the *constraints* that are derived from the situational context. Second, the patterns of *value commitments* and the degree to which actors in the organisation are satisfied or dissatisfied with the existing accommodation of their interests. These two concepts (*precipitating factors*) identify points of pressure on an organisation for change or for inertia. Third, *enabling factors* that could facilitate or impede the scale of change. This concept looks at the structure of *power dependencies* and the presence or absence of *organisational capacities* for change.

A basic idea of archetype theory is that there will be identifiable movement along an organisational track, as a process of constrained choice. Although external pressures could act as constraints and produce pressures, members of the organisation are responsible for interpreting and giving meaning to these situations and challenges.

### *Situational Constraints*

Control is a major factor to be considered when discussing organisational design choices. Government-funded organisations, such as hospitals, would have a different internal authority system than a private sector company (Hinings et al., 1988). Organisations that are regulated by the state will be constrained by the ideas and rules sanctioned by that body. Public sector hospitals, as state institutions, are forced to adapt and incorporate these prescribed and legitimated ideas about appropriate ways of operating (Scott and Meyer, 1983; Meyer and Rowan, 1977 and Zucker, 1984).

Similarly, a key constraining element in any organisational environment is the relative scarcity of resources. All organisations require a flow of money, people and equipment. The source and relative importance of these resources varies across organisations and each could place pressure on the organisation. Health care is no stranger to these pressures. As a knowledge-based service sector, it must have the people (workers) to provide the patient care and without adequate resources and medical technology its performance of its functions would be greatly jeopardised.

## *Value Commitments*

Values are prevailing conceptions of what an organisation should be doing, how it should be doing it and how it should be judged (Greenwood and Hinings 1988). Correlated values shape the interpretive scheme underlying an organisational design archetype.

One of the bases on which responses to external pressures may be predicted is the pattern of commitments by members of an organisation to prevailing and alternative correlated values. Four generic patterns of value commitment can be identified (Greenwood and Hinings 1988, 1996): (1) *status quo* commitment: a widespread commitment to the organisation's existing interpretive scheme; problems are solved through existing routines (2) *indifferent* commitment: groups are neither committed nor opposed to prevailing or alternative ideas (3) *competitive* commitment: some groups support the existing interpretive scheme while others advocate an alternative scheme and (4) *reformative* commitment: widespread commitment to an alternative organisational orientation and opposition to the existing one.

According to Greenwood and Hinings (1996): (i) a prevailing competitive or reformative value commitment makes the organisation open to radical change; (ii) interest dissatisfaction leads to radical change only if value commitments are competitive or reformative; otherwise, interest dissatisfaction leads to a convergent change; (iii) reformative commitment will be associated with revolutionary change; (iv) competitive commitment will be associated with evolutionary change; (v) radical change will not occur without an enabling pattern of power dependencies combined with either a reformative or competitive pattern of value commitments; (vi) radical change will not occur without a sufficient enabling capacity for action combined with either a reformative or competitive pattern of value commitments; (vii) high capacity for action will be associated with revolutionary change.

Value commitments and interests are internal factors precipitating change. They are necessary but not sufficient, to implement change; power and capabilities (enabling dynamics) are also required (Greenwood and Hinings 1996).

## *Power*

The role of power dependencies depends upon the pattern of commitment within the organisation. A concentrated power structure can facilitate imposed change or obstruct change: the result is dependent upon the commitment of the elite to particular interpretive schemes. A dispersed power structure does not facilitate change, especially in a situation of competitive commitments.

According to Greenwood and Hinings (1988), the way in which power can be used as a dynamic of change rests upon the distinction between dispersed and concentrated power. Power is concentrated when access to resources, key decision processes and information is restricted to a few groups or an elite. In a concentrated power structure, commitment of the elite to a particular interpretive scheme is needed in order to facilitate imposed change or to obstruct change. Power is dispersed when access to decision processes, information and resources is open and distributed among various groups, who may be able to effect or to obstruct change. The two power structures do not have to have opposite consequences.

Different groups in the organisation have differential power and some have more influence than others. It is particularly important to question whether archetype theory adequately recognises the impact of competing groups in organisations and their political interaction. Such phenomena are usually explored in good case study work on organisations, such as that produced by Andrew Pettigrew and William Starbuck. Pettigrew (1985:27) stated that:

‘the possibilities and limitations of change in any organisation are influenced by the history of attitudes and relationships between interest groups...and by the mobilisation of support for a change within the power structure at any point in time.’

Starbuck et al. (1978) found that existing powerful groups were frequently tied to prevailing ideas and structural arrangements because these were the basis of their power. Power could be seen as the capacity to determine outcomes, and structures that were used to obtain and utilise that power.



## *Organisational Capacity for Change*

According to Greenwood and Hinings (1996), the capacity for action necessary to implement change is determined by a combination of the following capabilities:

- (1) clear understanding of the new interpretive scheme and related systems and tools;
- (2) skills and competencies to design new organisational structures and routines; and
- (3) ability to achieve goals.

These capabilities can be concentrated in leaders or dominant groups, or diffused throughout the organisation. The first two capabilities refer to technical and professional expertise in designing and understanding an archetype, and can belong to multiple actors in the organisation. The ability to achieve goals is concerned primarily with the leadership or managerial attitude of the sponsors of change.

Some authors have suggested that managerial capabilities and leadership play an essential role in change processes: see for example Peters and Waterman (1982), Tushman and Romanelli (1985), Pettigrew (1985). The ability to manage the process is crucial in organisational transformations, because they involve restating values, direction and organisational forms.

In their study on leadership and strategic change in Canadian health care organisations Denis et al. (2001) found that the ability to achieve transformational change could be influenced by the capabilities and competencies of the organisation, which included both the leadership to drive the change and the expertise in developing a new organisational archetype. The leadership in the organisation has to have the power and articulated vision in order to mobilise strategic groups into effective coalitions. Leadership in an organisation may not always refer to one person but dominant coalitions that are structures of leadership (Hinings and Greenwood, 1988). A similar view was taken by Kanter (1983), who used the term 'prime movers' to describe senior people who took responsibility for the change, built the coalitions and mechanisms necessary for successful outcomes and at the same time demonstrated the commitment of the organisation to that particular change process.

## *The Concept of Sedimentation*

Organisational change is increasingly seen not so much as a shift from one archetype to another, but a layering of one archetype on another ('sedimentation'), in which values, ideas and practices persist even where the formal structures and processes seem to change, and despite incoherence. The idea of sedimentation within organisational structure dates back to Clegg's (1979) work on organisations as complex structures-in-motion that control the labour process through historically structured principles of organisation called 'rules' (1979:551-2):

'Within the organisation, different control rules evolve at different times and at different stages of functional complexity. Earlier rules may persist at different levels in the organisation, despite the later development of more complex rules. These rules may be represented as a superimposed series.....The layers of rules exist in a dynamic relationship with each other. The metaphor most apt for representing this layering is drawn from geology: sedimentation'

This concept is potentially useful for present purposes, because health care is a classic pluralist domain involving divergent objectives (population health, cost control, patient care) and multiple actors (professionals, administrators, community and government groups, and politicians) linked together in shifting and ambiguous power relationships. The public sector has become more complex and dynamic in recent years with multiple level changes and constant tension between the government and the health care community, and hospitals are an integral part of this interrelated pluralist network (Denis et al., 2001; Ashburner et al., 1996 and Kitchener and Whipp, 1997).

Some scholars have taken the view that 'sedimentation presupposes that a transition has already taken place' (Mueller et al., 2003:1992) whereas others see sedimentation as suggesting that 'organisations are constantly in flux, and different archetypes can dominate in different parts of the organisation' (Cooper et al., 1996:635). Similarly Flood (1999:155) argues that organisational change is best understood as the layering of one archetype on another because 'firms are products of histories, ideologies, cognitive scripts and reclaimed narratives that persist through time'. A further, rather dynamic interpretation is that sedimentation refers to the layering, erosion, conflicts and discontinuities (or eruptions) that can arise when multiple management systems

and traditions confront one another (Cooper and Ezzamel, 2005). In terms of wider issues in the study of organisational change, it has been argued that the concept of sedimentation 'has the advantage of side-stepping what is increasingly seen as a sterile debate about transformational and incremental change (DiMaggio and Powell 1991; Oliver 1992)' (Cooper et al., 1996:624). This is consistent with the views of Weick and Quinn (1999:382):

'Recent work also suggests that change is not an on-off phenomenon nor is its effectiveness contingent on the degree to which it is planned. Furthermore, the trajectory of change is more often spiral or open-ended than linear. All of these insights are more likely to be kept in play if researchers focus on 'changing' rather than 'change'.'

When applied in studies of change in hospitals and other health care organisations, archetype theory's concepts of design archetype has lead to an informative variety of findings.

Denis et al (1996) studied the processes of leadership development and strategic change in a large public hospital in Canada, using the archetype concept to define change in the organisation as it shifted from an 'Introverted General Hospital' (archetype 1) to a more 'Extroverted University Hospital' (archetype 2). The researchers identified shifts in the organisational design and its strategic framework.

Ashburner et al (1996) studied 'organisational transformation' and public sector restructuring in the UK during the 1990s. This study was primarily interested in looking at change across the whole NHS and is thus not directly comparable to the research in this thesis, but their theoretical findings are nevertheless useful. The authors thought they could not place the NHS currently within any of Hinings and Greenwood's (1988) four prototype tracks of change since what they had observed was the emergence of a new dominant subculture, influenced by private sector concepts and values but also retaining aspects of the old public administrative culture. Rather than Hinings and Greenwood's (1988) 'schizoid' model, they had observed a different model of 'hybrid change'. In this respect Hinings and Greenwood's model of prototypical tracks appeared rather linear and rigid, and insensitive to the complexity of change dynamics in the health care sector. The researchers felt unable to determine whether the process of organisational transformation to a hybrid model

of management seen in the study represented the final recoupling or was no more than a transitional phase towards a different destination (whether forward to a full organisational transformation or back to an aborted excursion).

Kitchener and Whipp (1997) investigated the 'process of change' or 'tracks of change' in NHS hospitals after the 1990 reforms. Their theoretical framework incorporated concepts from both the 'punctuated equilibrium' thesis of Tushman and Romanelli (1993) and Hinings and Greenwood's (1988) 'archetypes' and 'tracks of change'. They identified two forms of hospital sector development – adjustment and transformation. Their account of hospital archetype development led to the identification of an additional track of change that described the long-term evolution of hospitals. The track, labelled 'structural adjustment', was introduced to describe the pattern of minor and often structural alterations (such as the introduction of a clinical directorate structure in the hospital) that characterise hospital change prior to the introduction of transformational change.

Ashburner et al. (1996) and Kitchener and Whipp (1997) questioned the generalisability of Hinings and Greenwood's (1988) prototypical 'tracks of change' in more pluralist complex settings like the NHS.

A study of change in UK hospitals by Kitchener (1999) showed that as these hospitals were being persuaded by institutional factors to move from the professional bureaucracy archetype to a quasi-market archetype, what emerged was a hybrid structure with characteristics of the new quasi market archetype but with power relations, values and beliefs that had for the most part endured from the old professional bureaucracy archetype. The author observed that there was both continuity and change as the old and new forms of organisation and ideology coexisted so that archetypal change was 'sedimented'.

Exworthy et al. (1999) argue that the UK NHS shows characteristics of quasi-market, quasi-bureaucracy and quasi-networks all at the same time. They suggest a research agenda might 'embrace the changing mix across sectors, time and space. For example...How quickly do local organisations respond to policy shifts?' (1999:20).

Taken together, these findings may appear to imply some rigidity in archetype theory with regard to notions of a dominant interpretive scheme and prototypical tracks of change. However, it is important to keep in mind archetype theory's long-standing recognition of hybrid or sedimented forms. Also, one of the fundamental tenets of archetype theory is that change may follow a number of different tracks (ranging from transformatory to aborted) and, in most cases, occurs over time. The importance of the time factor is apparent from the following passage from Greenwood and Hinings (1996:1030-1031):

‘..... we admit to the possibility and even the likelihood of alternative templates within an institutional context. .... The central point is that organisations are recipients of prescribed ideas about appropriate templates of organizing whose relative salience and clarity may change over time. Particular organisations do not respond to a template of organizing, but they do respond over time to evolving and competing prescriptions’.

Similarly, in the context of professions, Scott et al (2000) observed that changes in governance structures (such as professional regulatory arrangements) ‘tend to lag’ (2000:175) the development of new ideas and build up of political will. The researcher would acknowledge that archetype theory leaves open the question of how long an organisation can accommodate hybrid or sedimented forms of organising, but sees this as a matter for empirical investigation and inductive analysis.

An interesting pointer for possible future research with regard to sedimented arrangements can be found in McNulty and Ferlie's (2004) recent study of the implementation of business process reengineering (BPR) in a UK NHS hospital. The authors found a counterintuitive pattern of collaboration between clinicians and local managers against senior management and external change agents. The ‘sedimented’ arrangements observable within this UK hospital thus showed unexpected resilience. The authors argue that the stability and durability of the clinical/managerial hybrid form helps to explain why clinicians and managers were able to ‘fend off’ the prospect of process-based organising arrangements. The resilience of these sedimented arrangements is of theoretical and practical significance for several reasons (2004:1408):

‘First, sedimented conditions have previously been theorized as schizoid and insecure forms (Cooper et al. 1996). Second, sedimented conditions in healthcare (Kitchener 1999) exhibit an unforeseen coherence more supportive of functional rather than process organisation. Third, the unlikely collaboration between managers and professionals found in this instance suggests that managerial-professional relations are more nuanced and contingent than some earlier literature suggests’

The authors suggest (2004:1408) that research and debate about sedimentation needs to progress beyond an interest in explaining the creation of sedimented conditions as an outcome of institutional pressures for change,

‘..to an interest in understanding sedimentation as a critical condition of dynamic professional service contexts that shapes the process and possibilities of further organisational change.’

Thus, contemporary archetype theory is moving away from a perception of hybrid conditions as schizoid and unstable. Further, whilst hybrid conditions may still be viewed as ‘transient’ (Kirkpatrick and Ackroyd, 2003:734), this can be interpreted as a dynamic of further organisational change toward an end point that is not predetermined (Laughlin, 1991), and in the meantime the hybrid may exhibit resilience and unforeseen coherence. The researcher would argue that this contemporary perspective adequately addresses Kirkpatrick and Ackroyd’s (2003) critique (see above): hybrid forms are no longer viewed as being necessarily unstable or abnormal. It is noted that Kirkpatrick and Ackroyd’s critique pre-dates these important findings of McNulty and Ferlie (2004).

### ***Professional Groups in Organisations***

Much of the literature dealing with sedimented or hybrid archetypes concerns the conflict and tensions between professional elites (e.g. medical professionals) on the one hand and managers on the other arising from their differing provinces of meaning, usually exacerbated by the ‘colonisation’ (Laughlin, 1991) of the public sector by New Public Managerialism since the mid-1980s.

With regard to professional groups themselves, Kirkpatrick and Ackroyd (2003) argue that archetype theory is weakened by what Pinnington and Morris (2002:195) describe as its ‘uncritical generalisation across different professions’. Based primarily on

studies of law and accountancy firms, archetype theory views professional organisations as semi-autonomous entities guided by professional interests and concerns embodied in a unified interpretive scheme. Against this the authors argue that professional groups operating in organisations in the public domain such as hospitals, local authorities and schools are not autonomous but, to a greater or lesser extent, 'structurally subordinated' with only limited freedom to 'pursue their own distinct interests' (Brint and Karabel, 1991:353). The ability of professionals to regulate and shape practice is also heavily circumscribed by national legislation, policy guidelines, administrative hierarchies and cash limits. Managers impose non-technical or non-clinical criteria on service provision, which constrain professionals. The ability of professional groups to negotiate degrees of de facto control over service provision at operational levels is limited by an overall structure that circumscribes their power to self-regulate. Thus, Kirkpatrick and Ackroyd argue, it is not correct to describe organisations in the public domain as autonomous or as entirely shaped or dominated by professional concerns and interests. Also, and following on from that criticism, the authors argue that archetype theory appears to make the generalised assertion that professional groups play a key 'entrepreneurial role' in processes of negotiation within fields (Hinings et al., 1999; Powell et al., 1999). However, in public services especially, the suggestion that professional groups have driven change is difficult to sustain. Kirkpatrick and Ackroyd (2003), citing recent literature, note that a variety of coercive top-down mechanisms have been used by governments to impose change including central performance targets for health, education and social care, league tables and even threats of direct intervention in the case of 'failing' services. They argue that in archetype theory, these dynamics of more coercive change are rarely discussed or fully explained.

There is certainly some support for Kirkpatrick and Ackroyd's view. In the UK, at least, from the early 1980s governments were less than willing to involve professions in the development of new policy. For example, the NHS review of 1988 (leading to the *Working for Patients* reforms) was 'conducted informally, largely in secret and uninformed by expert opinion from the field' (Harrison and Wood, 1999:757). In this research, the researcher's case studies will reveal empirically the extent to which the professional groups were able to act autonomously in Newcastle upon Tyne, England and in Hamilton, Ontario. However, the researcher will not be relying on archetype

theory to analyse the interaction of professional groups with managers or other actors in the pre-merger change process (she will be drawing on Fligstein's work to analyse the dynamics of such interaction). In the pre-merger phase of the cases, it may be expected that the primary preoccupation of medical and nursing professionals will not be on internal professionalism – managerialism issues, but, rather, on how the merger restructuring will affect their patients and themselves personally (possible job losses, increased workload and so on). In the post-merger phase in each case (i.e. the period immediately following the decision to merge, in which the new entity formed by the merger seeks to implement the merger changes) the organisational focus shifts from the plural merging hospitals to a single hospital (the new entity formed by the merger); archetype theory will be used to analyse the nature of the emerging organisational design (archetype or hybrid, as the case may be) of this entity.

The researcher's approach is consistent with that taken by Mueller et al. (2003) who employed archetype theory and action strategy in their study of the aftermath of the creation of a new governance structure in the UK NHS. The authors suggest that it is important to differentiate between the debate concerning the sedimentation of bureaucratic and professional values in professional (including health) organisations, and the debate concerning the introduction of NPM. The authors note that whilst doctors can accept management as a technical necessity, they have found it harder to accept NPM's challenge to their values (Exworthy and Halford, 1999:12), which questions, for example, the legitimacy of traditional professional bodies (Exworthy and Halford, 1999:9). Indeed, the authors suggest, the changing political climate will not affect every organisational context in the same way. In order to appreciate how the dynamics of management - professional conflict is 'regulated through the deployment of various negotiating processes' (Reed, 1996:584) in *differing* organisational contexts, Mueller et al.(2003) employed 'two related concepts: action strategy (or scripts), and archetype (transition)' (2003:1974). Based on their findings, they argued that (especially but not only) in pluralistic organisations one should not be too surprised to find an ongoing contest between interpretive schemes, and between processes associated with conflicting interpretive schemes.

The use of archetypes in the analysis of change in professional service organisations (including hospitals) is, the researcher would argue, further supported by the shift in



current organisational and sociological thinking away from the notion of professionalisation as a project of social closure (MacDonald, 1995:50-55). In a study of professional – management relations in the context of a threatened hospital closure, Dent (2003) notes an increasing involvement of professionals in management (Causser and Exworthy, 1999), an increasing acceptance of ‘commercialised professionalism’ in the private sector (Hanlon, 1998: 51) and a recognition of ‘professionalism’ as part of the managerial armoury. Thus, Dent argues, ‘the emphasis is now more on the configuration of relations, rather than binary oppositions’ (2003:108). This, the researcher would suggest, invites the application of archetype theory’s holistic perspective, from which new archetypes such as ‘commercialised professionalism’ may be identified as they become established. Dent’s (2003) study found that the hospital doctors, being less accessible to the disciplinary power of management, were not so susceptible to the ‘managerialisation’ of professionalism and that there was a ‘persistence of values and practices’ (Kitchener, 1999:185). Thus, whether through the contemporary concept of sedimentation or through the establishment of newly emerging interpretive schemes and associated structures and systems, the researcher argues that archetype theory is useful for the analysis of professional service organisations.

## **2.4 The Organisational Field**

DiMaggio and Powell (1983) argue that bureaucratisation and other forms of homogeneity emerge out of the structuration (i.e. institutional definition) of organisational fields, which they see as a process effected largely by the state and the professions, which had become ‘the great rationalisers of the second half of the twentieth century’. The authors defined the organisational field as ‘those organisations that, in the aggregate, constitute a recognised area of institutional life: key suppliers, resource and product consumers, regulatory agencies and other organisations that produce similar services or products’; this unit of analysis directs attention not simply to competing firms or to networks of organisations that actually interact, but to the ‘totality of relevant actors’. (DiMaggio and Powell, 1983:147-148). This is an important distinction, because ‘organisations compete not just for customers

and resources, but for political power and institutional legitimacy, for social as well as economic fitness' (DiMaggio and Powell, 1983:150).

In the context of a highly structured organisational field, the individual efforts of organisational actors - including new entrants to the field - to deal rationally with uncertainty and constraint often create an environment that constrains their ability to change further in later years (DiMaggio and Powell, 1983:147-148). This is the result of coercive, mimetic and normative processes through which, paradoxically, rational actors make their organisations increasingly similar as they try to change them.

Fields have been further defined in terms of shared cognitive or normative frameworks or a common regulative system: participants directly interact with one another or are influenced by each other in a meaningful way, and the patterns of interaction are defined by shared systems of meaning. These meaning systems or 'institutional logics' establish the boundaries of each community, creating the grounds of membership and appropriate behaviours; that is, they define activities appropriate for particular communities and how they should be organised and formed (Scott and Meyer, 1991; Scott, 1995). Changing eras in health care in the USA have been connected with alterations in institutional logics (Scott et al. 2000; Kitchener 2002).

The significance, then, of the organisational field is that an organisation's action is seen not as a matter of free choice determined by its internal arrangements, but as limited to a narrowly defined set of legitimate options determined by the group of actors that make up the field in which the organisation participates. The field can consist of any actor that exercises a coercive, normative or cognitive influence on a given focal organisation or population of organisations, and may include the government, critical customers and suppliers, sources of funding, professional and trade associations, special interest groups and the general public (Scott, 1991).

Organisational transformation may be analysed at the level of a single organisation (for example a hospital) or across an organisational field (the health care sector) (Ferlie, 1999). Brint and Karabel (1991) argue that the concept of organisational field makes a valuable contribution to institutional analyses of organisational change; they found that both the origin and the realisation of agents' interests are shaped and

channelled by the forces of external and internal institutional arrangements, such as power structures, field opportunities, and ideological orientations. This perspective is particularly useful for the purposes of this research because it is at the organisational field level that we see the horizontal and vertical relationships and interaction between the organisations in the local health care sector (Scott et al. 2000) as they respond to market and institutional pressures, including interaction that reflects the influence of the government (through its various agents) and the health care professions. As Dent (2005:627) observes :

‘...the ‘new institutionalism’... has a certain usefulness, particularly for cross-comparative studies, and the framework does offer the opportunity, as Kitchener (1998:73-4) points out, to break out of the ‘insular and parochial’ disciplinary boundaries of much work on public sector organisations. Hospitals, for example, can usefully be viewed as being part of an organisational field.’

## **2.5 Organisational Change in New Institutionalism**

Up until the early 1990s the theory focused on the isomorphic processes of organisational change that explain the homogeneity of organisational structures within an organisational field. Central to this perspective are the legitimation forces through which key players in the field orient their actions toward one another and partake of taken-for-granted archetypes of organising that both shape and constrain collective action (Meyer and Rowan 1977; DiMaggio and Powell 1983; Scott 1991). Institutions have been variously defined as ‘socially constructed, routine-reproduced programs or rule systems’ (Jepperson, 1991:149) and ‘supra-organisational patterns of human activity by which individuals and organisations produce and reproduce their material substance and organise time and space’ (Friedland and Alford, 1991:243). Institutionalists themselves have acknowledged that this perspective, in which actors and their interests are themselves institutionally constructed, obstructs agency and interest and thus cannot explain how institutions change (DiMaggio and Powell, 1991). Attempts have been made to correct this through various formulations of the relation between institutions and agents. Powell (1991) contends that individual preferences and choices can only be understood in the larger cultural setting and historical period in which they are embedded. Brint and Karabel (1991) found that the origin as well as the realisation of agents' interests are shaped and channelled by forces imposed by external and internal institutional arrangements, such as power

structures, field opportunities, and ideological orientations. In the same vein, Goodrick and Salancik (1996) argue that the direct incorporation of a strategic choice perspective into institutional theory would risk contradicting an essential premise of institutional theory: the social-fact quality of institutions.

The emphasis on the institutional embeddedness of interest and agency underlying these approaches leads, however, to another dilemma: 'How can actors change institutions if their actions, intentions, and rationality are all conditioned by the very institution they wish to change?' (Holm, 1995:398). Holm (1995) criticises the rationalist perspective on institutions, in which institutions are seen as instruments created to provide efficient solutions to predefined problems, thereby helping to align individual and collective interests. Holm argues that this 'disregards an important aspect of what institutions are, namely, frameworks for action and, as such, outside the scope of strategic manipulation' (1995:398). Holm also criticises the new institutionalist perspective, which view institutions as 'socially constructed, routine-reproduced, program or rule systems' (Jepperson, 1991:149) where behaviour is governed by norms. This, Holm argues, this ignores the processes by which institutions are formed and reformed, which tend to be interest-driven and highly political. Holm (1995) proposes a 'nested system' model based on a distinction between actions guided by the established institutional order ('practical' or 'first-order level' action) and actions geared toward creating new institutions or changing old institutions by manipulating institutional parameters ('political' or 'second-order level' action). This distinction, Holm argues, 'makes it possible to retain the insight that institutions are products of action, and therefore constructed for some purpose, without giving up the notion that institutions are frameworks for action, and therefore taken for granted' (1995:399). Institutional change may originate at either of the two levels of action: how this comes about depends on the relationship between the two levels. There appears to be a problematic limitation in Holm's model, which is apparent from his description of the relationship between the two types of action. Arguing that the relationships between levels are structured, Holm says:

‘This means that there will be rules defining what type of problems at the first-order level of action can legitimately be considered at the second-order level, the proper procedures for doing that, who can participate in decision making, and so on. It also means that there will be rules defining and limiting the authority of the second-order level toward the first-order level’ (1995:400-401).

The problem here is that Holm’s model does not explain how, and under what circumstances, these rules may themselves be changed by agents.

More recent studies of change within institutional frameworks have shifted the focus from isomorphism and the creation of fields, to dynamics of institutional change involving movement away from an established and taken-for-granted status quo. An organisational field should be seen, not as static, but as evolving through the entry and the exit of particular organisations or populations (Barnett and Carroll, 1993, Fligstein, 1996) and/or through alteration of the interaction patterns and power balances among them (Brint and Karabel, 1991; Greenwood and Hinings, 1996).

Fligstein (1998:11) observes that new institutionalists view fields as ‘interactions between more and less powerful collective groups according to rules and shared meanings’ and argues that the critical problem is to develop a more social, collective conception of action that gives rise to a better understanding of what actors do to produce or reproduce institutions. This understanding will, Fligstein argues, be informed by a conception of fields as ‘institutionalised arenas of interaction’ where ‘the rules of the arena shape what is possible by providing tools for actors to interact, and are the source for actors to think about what their interests are, interpret what other actors do, and, strategically, what they should do.’ (1998:29) In this vein, studies have addressed the increasing demand for strategic insights by extending new institutional theory’s ‘limited theory of action’ (Fligstein 1997:397) through emphasising the role of power and agency (Greenwood and Hinings 1996; Barley and Tolbert, 1997, Fligstein, 1997; Beckert 1999) and diversity (Kondra and Hinings 1998).

Greenwood and Hinings (1996) recognised that institutional theory was not usually regarded as a theory of organisational change, but more usually as an explanation of the isomorphism and stability of organisational arrangements within established

populations or organisational fields. They (along with some other scholars) nevertheless took the view that the theory contains an excellent basis for an account of change, first, by providing a convincing definition of radical (as opposed to convergent) change and second (and more importantly for present purposes), by highlighting the contextual dynamics that precipitate change. However, they noted that new institutional theory did not explain why some organisations adopt radical change whereas others do not, despite experiencing the same institutional pressures. For the purposes of the research presented in this thesis, this is an important question. The authors proposed to elaborate the theory's insights by combining the new institutional emphasis on persistence (through legitimacy, the embeddedness of organisational fields and the centrality of routines and scripts) with the 'old' institutionalist conception of change as a dynamic of the organisation as it struggles with issues of influence, power, coalitions and values. This model of change, linking organisational context and intraorganisational dynamics, would explain the response of the individual organisation to pressure in the institutional field as a function of the organisation's internal dynamics, showing how the characteristics of the organisational field interact with the internal dynamics of an organisation (Greenwood and Hinings, 1996).

Seo and Creed (2002) have argued that in Greenwood and Hinings (1996) work, the two institutionalisms are not really integrated but conceptualised as two separate processes one of which (comprising normative pressures operating in the institutional context) influences the other (agents' political action within the organisation). This leaves open the question of when and how local agents change the institutional context itself. The researcher would suggest however that Greenwood and Hinings have anticipated, and to some extent at least, addressed this issue. Greenwood and Hinings (1996) point out that in their model for understanding organisational change' (helpfully shown in diagrammatic form at 1996:1034), radical organisational change, which is shown as the outcome of intraorganisational change dynamics, would become the input to market and institutional contexts. For example, if following radical organisational change an organisation achieved competitive success in the market, this would put pressure on other organisations to adopt the same organisational form. 'Organisations, as Fligstein (1991:316) noted, 'extensively monitor one another', and successful practices are mimicked and institutionalised'

(1996:1033). In this way, local agents would indeed have brought about a change in the institutional context through the radical change of their own organisation. Of course, organisations which do undergo radical change may not always be successful and mimicked. The researcher therefore considers Seo and Creed's (2002) critique remains valid in respect of these situations and, as will be seen, proposes that the question of when and how local agents change the institutional context is, to the extent not answered by Greenwood and Hinings (1996) model, answered by the political-cultural perspectives incorporated in her chosen theoretical framework.

## 2.6 The Researcher's Use of Archetype Theory

Thus far, the researcher's analysis of archetype theory has established five useful elements of a robust theoretical framework for analysing the change processes in the cases under study: (1) an important organisational starting point, which may be a single or several design archetype(s), or a hybrid that can be identified by reference to one or more design archetypes; (2) a general outline for establishing and finding such archetype(s) (the coherence of meanings, structures and processes, locating any ideal template(s) in the institutional field); (3) an organisational end point of change, which may be a new, or the same, archetype or hybrid (4) a means of tracking change and determining whether there is any loss of design coherence and any displacement of underpinning interpretive schemes over time; and to see configurations of interpretive decoupling in order to observe whether the organisation does or does not move between archetypes and at what pace and (5) an understanding of the internal dynamics of the *new hospital entity* created by the merger in England and of the *new hospital entity* created by the merger in Ontario in the early *post-merger* period as they attempt to *implement* changes (be they radical or not) following the decision to merge.

The researcher emphasises the limitation of the fifth element. The researcher considers that archetype theory's focus on intraorganisational dynamics is appropriate and indeed very useful for explaining individual organisational change and differing responses of *individual organisations* to similar external pressures for change. However the researcher does *not* consider that that theory alone is adequate to explain

differences in the outcome of two hospital merger case studies in so far as they arise from the *pre-merger* processes and interactions between the various actors. In the pre-merger phase each case study involves the interaction, in the process leading to the decision to merge, not only of groups within an individual hospital, but of a large cast of players both internal and external to the hospital, including the other local acute hospitals, other health organisations, community groups, professional groups and of course government agencies. There is perhaps an interesting question as to whether the theory can be projected onto a population of organisations (for example all acute hospitals in Hamilton, Ontario) as well as an individual organisation (one acute hospital). If that were so, then *intra-population* dynamics could be analysed in the same way as individual organisational dynamics, and any difference in the outcomes of the two case studies (notwithstanding similar external pressures on the populations), could be explained by reference to *intra-population* dynamics. This question is not entirely hypothetical and arises out of the distinction drawn by some scholars between an organisational field and individual populations within it, or ‘classes of organisations that are relatively homogenous in terms of environmental vulnerability’ (Hannan and Freeman, 1977:166). Thus, according to Hoffman (1999:352):

‘A field is more than just a collection of influential organisations; it is the centre of common channels of dialogue and discussion. It is not formed around common technologies or common industries but around issues that bring together various field constituents with disparate purposes: that is, issues that become important to the interests and objectives of a specific collective of organisations. Issues define what the field is, making links that may not have previously been present.’

The concepts of interest dissatisfaction, value commitments, power dependencies and capacity for action (Greenwood and Hinings, 1996:1034) would appear, logically, to be as appropriate to a specific collective of organisations *sharing common interests and objectives in relation to field-forming issues*, and facing similar external pressures, as they are to an individual organisation. The researcher however does not purport to explore this interesting question in this research. Instead, the political-cultural approach of Fligstein will be used.



## 2.7 Adopting the Political-Cultural Approach - A Dialectical Perspective

Seo and Creed (2002) used a dialectical perspective to provide a framework for understanding institutional change as an outcome of the dynamic interactions between institutional contradictions and human praxis (i.e. political action embedded in a system of interconnected institutional arrangements); they proposed that this would reconcile institutional embeddedness and transformational agency (2002:223). In this model, institutions change as a result of agents' ability to mobilise different institutional logics and resources to frame and serve their interests (2002:240). This approach is broadly similar to notions of shifts in ideologies, social structures and power leading to the destruction of one legitimacy and replacement with another (Holm 1995; Kitchener 2002).

Seo and Creed (2002) argue that the dialectical framework highlights the pivotal role of actors' ability or skills to mobilise institutional logics and resources from the heterogeneous institutional environments so as to legitimise and support their change efforts. Such tasks are extremely difficult and challenging and, the authors argue, many of the analytical models and managerial skills that traditional organisational theories and practices have promoted seem inadequate for addressing such a challenge. For example, stakeholder analysis (2002:242):

'stakeholder analysis (e.g., Freeman, 1984; Jones & Wicks, 1999) is a model of political analysis frequently used to identify, classify, and shape strategic responses to the individuals and groups who can affect and/or are affected by organizational actions or who have enforceable claims on a firm's performance. However, it is a static and a historical model. With its focus limited to the functional and legal dependencies of the firm, it is incapable of capturing the multiple logics and rules that arise from the institutional environment and of handling the dynamics and historical relationships that embed organizations and organizational members.'

Discussing the implications and limitations of their dialectical analysis of institutional change, Seo and Creed emphasise the need to firmly establish its validity and usefulness by empirical research, and suggest future research should (2002:243):

‘[focus] on microsociological aspects of institutional entrepreneurship. We have proposed that research on institutionally embedded agents, the practitioners of praxis, should focus on the interplay of their actions, skills, social locations, and identities. This interplay has implicitly figured prominently in Fligstein's (1997) depiction of institutional entrepreneurs and their critical actions. Many of the actions he highlights echo key features of praxis (a particular type of human agency which is political action embedded in a historical system of interconnected yet incompatible institutional arrangements) using the components of existing meaning systems to frame alternative legitimating logics that challenge existing cultural templates, promulgating new meaning systems, and creating new shared social identities and roles as a means of mobilizing collective support for these alternative social arrangements. Just what each of these actions looks like empirically in an institutional context warrants research.’

Seo and Creed's approval of Fligstein's (1997) model of institutional entrepreneurship supports the researcher's choice of such model (elaborated in Fligstein's later work, 2001) as a theoretical framework that will provide a microfoundation for analysing social action and overcome the problem of embedded agency.

## **2.8 Fligstein's View: The Importance of Power, the Role of Actors and Social Skill**

Although Fligstein's more recent work (1997, 1998, 2001) is of particular relevance to this research in terms of institutional entrepreneurship, his earlier work will also be discussed as it provides useful insights into issues of power, organisational fields and the state.

Fligstein (1990) develops a theory of corporate transformation based on a sociological framework. Fligstein sees organisations as embedded in organisational fields defined in terms of product line, industry, firm size or suppliers, distributors or owners. The state sets the rules of behaviour within which corporations employ strategies, structures, and technologies that shape and constrain their patterns of growth. These organisational fields are not benign but are set up to benefit their most powerful members.

Fligstein (1990) describes the strategy of American business before 1920 as a manufacturing-based attempt to control markets through price leading and vertical integration. He cites a shift, beginning in the 1920s, to sales and marketing strategies

of diversification, which aimed for growth through increased sales. According to Fligstein, these shifts in strategy corresponded with a change in the locus of power within organisations from manufacturing to sales and marketing personnel. He argues that the emergence of a new strategy (such as diversification) requires 'shocks' to stable organisational fields, and that in the post-1920 period the state provided two such shocks: the Depression and the growth of federal anti-trust policies which outlawed strategies of growth through product-related mergers. Diversification and antitrust action provided essential conditions for the rise of the current financial conception of control. This emphasises the use of financial tools that measure performance according to profit rates. The most important goal had become keeping the stock price above book value because if the assets are undervalued the firm would become a take-over candidate and management could lose their jobs.

Fligstein (1990) attempts to document this evolution from the historical perspective of the actors involved, in order to demonstrate that what has survived is not necessarily the most efficient form but rather it has come into existence as a result of a social and political process that defines and redefines markets. His theoretical approach focused on the *role of power* in organisational change and how the actors in organisations could use this power.

Fligstein (1990) criticises the historical view that the market is the source of efficiency, and points out that this approach places the market outside the social process. Fligstein (1990:302) observes that:

'the forms of social organisation produced the market, not the reverse....The interpretation of the history of the corporation that stresses efficiency ignores the central fact that managers and entrepreneurs were constantly trying to escape or control competition, not engage in it...the rules of the market could be changed by powerful corporate actors and the government.'

For Fligstein, markets are comprised of social structures or sets of rules which preserve the power and interests of the largest organisations; and when the rules no longer produce positive results for those in control, the rules are changed. Fligstein's sociological conception of the corporate organisation has the advantage of recognising there is no absolute standard of efficiency or mode of organisation which exists objectively outside social constraints. The rules by which worlds are constructed are

constantly negotiated and changed. The market as the driving force of economic history is replaced by a variety of institutional constructs. Fligstein argues (1990:304):

‘By dropping the notion that the most efficient economic solution is the predominant one and accepting that efficiency is a social construction, one can then see how the transformation of conceptions of control and their strategies rely on organisational dynamics and the interaction between organisations, their leaders, and the state.’

Similarly, in his study of how the largest corporations in the United States were transformed over a 100-year period, Fligstein (1991) analysed the strategic interactions between key actors in the organisations, the government and other external organisations in the same organisational field.

Understanding the importance of power and the role of actor(s) in organisational change is crucial if we are to develop our understanding of ‘how’ mergers evolve. Fligstein (1990:311) stated that:

‘the ability to change large organisations depends on a complex set of action, both internal and external to the organisation and it is both the ability and power base of individual actor(s) and groups that can affect organisational actions and outcomes.’

As an institutionalist, he recognised that organisations operate in three contexts or what can be called institutional spheres: the existing strategy and structure of the *organisation*, the set of organisations comprising the *organisational field* and the *state*. These three contexts are where rules are created, meaningful action occurs, power relations are formed and concrete forms of social organisation are set in place. The rules in this definition act to constrain and shape the actors behaviour. The ability to set the rules can be a result of power (Fligstein, 1990).

### ***Power Dynamics***

Power is a means by which actors or groups of actors are able to persuade, induce or coerce others into following certain courses of actions. Most organisational power will be unequally shared between various groups. Even though the motives of the merger can be open to amendment and change as the merger process progresses, often actors of the dominant group(s) can be very influential. The power status of each actor and

group is assessed according to their position in the organisation, their specialist knowledge or skills, their influence in the external environment and their control over resources (Fligstein, 1990).

Pluralist organisations, like hospitals, are characterised by fragmented power, multiple objectives and conflict between groups. These would be expected to intensify, especially during major organisational change and restructuring, when expectations of what the merger will mean, bring and result in is usually different between groups (Mueller et al., 2003; Ashburner et al., 1996). This tension or power struggle can be resolved in two ways; one by exercising control and the other is to reach a conciliatory compromise.

Control is about one party improving its power position over another. Depending on the position of the actors in the organisation, each would create a different view about how control should be achieved. Therefore their actions will be justified as ways to extend control over the situation or perceived problem. Internal control may have been about senior management making sure that resources were available so their directives could be executed, while external control could be about building coalitions or aligning themselves with other groups they perceived as powerful (Fligstein, 1990).

While compromise was about negotiation and agreeing on strategies and actions that were mutually satisfying to all parties, actors must be willing to reformulate power relationships between themselves and understand what they might have to concede in the short term in order to benefit in the long term.

### ***The Importance of Actors***

Archetype theory appears to side step the importance of external actors in organisational change. Organisations are seen as a system of power held together by the interests of key actors. A given system of power benefits those who are in charge and their views control the organisation and allow them access to the resources of the organisation. Fligstein's (1990) view suggests that if organisational fields/environments are turbulent and unstable, the actors must develop a set of solutions based on their interpretation of those problems. The actors in charge must

have both a perception of some new strategy and the power to act upon it. When actors are in key positions (leadership), they can mobilise themselves and others which gives them the power to force strategies and structure change (Fligstein, 1990).

The actors' position in the organisation or group would often influence their perception of the problem. That position might provide arguments or interpretations that would alter the organisation's course by offering a particular construction of the organisational crisis and a solution to that crisis. Such a solution would often enhance the power of that actor in the organisation or the position of that organisation in the organisational field (Fligstein, 1990).

Fligstein (1991) claims that his view of actors differs from that of traditional rationality or bounded rationality. Rationality assumes perfect information and 'maximisation', while bounded rationality assumes imperfect information and 'satisfying'. Fligstein claims that both approaches assume that information is 'neutral' and does not require interpretation. Fligstein however offers a view of actors as filling an interpretive (exercising cognition and perception) role in uncertain environments.

When a group of organisations in a specific field change their strategies or actions and other actors or groups perceive that this change has given their colleagues or competitors a beneficial result, then other actors in the field would probably follow suit (Fligstein, 1991). The proposed changes may or may not be positive for other organisations but what mattered was that actors in other organisations perceived the need for change and constructed views based upon their perceptions.

### ***The Organisation***

The internal structuring of the organisation was a source of great power and at the same time, a constraint on action. Those who were in power would act to preserve their position through claims exercised through both formal and informal authority structures. Changes in organisational goals or strategies would only result when either a new set of actors gained power or it was in the interest of those in power to do so. The strategic decision to pursue change initiatives or restructure the organisation was a leadership privilege based upon their power position in the organisation.

## *The Organisational Field*

Organisations are embedded in larger groups of organisations. The links between these organisations could be characterised in network terms. This was probably most evident in the health care sector. The other organisations in the environment could influence the action of any given organisation both through these network links and various dependency relationships (Fligstein, 1990). In an organisational field the actions of one organisation could have consequences for others. Therefore, the merger between two hospitals could have a significant impact on other health care organisations in this sector.

As defined by Fligstein an 'organisational field' is distinct from the concept of a niche. He states that the concepts share a conception of an objective external reality imposed on an organisation. But he claims (Fligstein, 1991:313-4):

'The idea of a field suggests that the environment and the niche are themselves constructions of organisations and their key actors.'

One important aspect of the organisational field concept was the ability of a given organisation or set of organisations to direct the actions of the field. Organisations could control fields on the basis of two principles. First, the size of the organisation gave its actors differential power to dictate the actions of others in any given field, and actors from larger organisations were more likely to use this power to influence others. Second, where all members expected to benefit from the formation of stable rules governing legitimate actions in the field, this would usually encourage group co-operation and compliance (Fligstein, 1991).

This view of organisational field differs from archetype theory, which stresses the normative aspect of organisational fields. The view put forward by Fligstein (1990) focuses instead on the organisational field as a construction of powerful organisations based on the interests of those organisations. The function of the organisational field is to promote stability and a sense of interdependency between organisations and other actors.

## *The State*

The state consisted of multiple organisations and institutions whose political function was to establish policies and legislation that would define the rules and boundaries of organisational behaviour. The government could mediate among organisations in the field and attempted to act in the interests of all organisations in order to stabilise the fields. Therefore, it could alter the environment more profoundly and systematically than any other organisation.

The actors who controlled the state achieved power through different means than the actors who controlled private and non-profit organisations. But once the actors were in power, organisational dynamics became important determinants of action. Sometimes the actions of the state provided shocks to the system that brought about unexpected consequences and forced transformational change through the organisational field (Fligstein, 1991). The government could exert profound power and control through the use of economic sanctions.

Therefore the *state* and *actors* are pivotal in understanding organisational change because of their *power* to influence organisational decisions and actions.

## *Social Skill*

In more recent work Fligstein (1998, 2001), incorporating and elaborating the model of institutional entrepreneurship in Fligstein (1997), observes that the various new institutional theories all agree that institutions are created to produce local social orders, are social constructions, fundamentally about how powerful groups create rules of interaction and maintain unequal resource distributions, and yet, once in existence, can enable as well as constrain actors in subsequent institution building. Fligstein criticises these theories for their inadequate attention to the role of social power and actors in the creation of institutions, and proposes an alternative view of the dynamics of institutions based on a more sociological conception of rules, resources, and social skill. Social skill is a 'microfoundation' for clarifying from a sociological point of view 'how to make sense of what actors are doing in groups and organisations' (2001:112).



Fligstein draws on the 'new institutionalist' concept of fields, defined as institutionalised arenas where organised groups of actors gather and frame their actions vis-à-vis one another. The rules of the arena shape what is possible by providing tools for actors to interact, to formulate their own interests and strategies, and to interpret those of others. Fligstein observes that although new institutional theories focus on how collective social actors orient action towards one another, these theories disagree on the role of actors, and the related problem of the role of power. He criticises the conception of actors in both rational choice and sociological versions of new institutional theories and develops a more sociological idea of action called 'social skill', defined as the ability to induce co-operation in others. It should be noted that Fligstein does not claim to offer a full-blown theory of agency or institutions, or to present a set of testable hypotheses:

'Instead, I am providing an abstract conceptual framework that supplies empirical sociologists with a set of tools that may help them analyze the role of actors in the emergence, stability and transformation of many kinds of local social orders' (Fligstein, 2001:106).

Rational choice models suggest that institutions are the outcome of individual rational actors interacting in game-like situations where rules are given and resources, indexing the relative power of actors, are fixed. Actors are conceptualised as individuals even when they represent groups and so the nature of social arenas and the role and position of actors in those arenas are undertheorised. States, political processes and power are considered to be rules and resources; and once these are known, actors' interests and thus their actions follow. Fligstein argues that these theories miss the point that actors (decision-makers, managers, leaders, or elites) have many constituencies to balance off and need to produce arrangements to induce co-operation with both their allies and opponents. Rational actor models, by treating rules and resources as exogenous and actors as individuals with fixed preferences, miss the creativity and skill required for individuals, as representatives of collectivities, to operate politically vis-à-vis other actors to produce, reproduce, and transform institutional arrangements (Fligstein, 2001). Sociological institutionalists focus instead on how social worlds are murky and require interpretation, and on how actions may or may not have consequences (Meyer and Rowan, 1977). To deal with this uncertainty, actors use readily available scripts, often provided by governments or professionals, to interpret the actions of others and to structure their interactions

(DiMaggio and Powell, 1983). Actors in these theories are more socially embedded and more collective. But the theory of action is about how local cultures and social positions in fields dictate what actors think and do, and not about interaction (Fligstein, 1998, 2001).

Most versions of new institutional theory in sociology lack a theory of power as well, which is related to the problem of the theory of action. Institutions provide collective meanings which structure fields, but the question why fields should exist and in whose interest they exist has never been a focus of institutional theories. Field analysis and dynamics is rarely about power, about who is benefiting, and who is not. The theory of action fosters this turn away from issues of power by making actors the propagators of shared meanings and followers of scripts. But, asks Fligstein, why and how do actors who are supposed to only be able to follow scripts create new institutions? (Fligstein, 1998). Most versions of the new institutionalism in sociology lack a real theory of interaction and power, and so have no way to make sense of how institutions emerge in the first place (DiMaggio and Powell, 1991; Scott, 1995).

Fligstein (1998) argues that the idea that strategic action occurs in fields requires the notion of social skill, defined as the ability of actors to induce co-operation in other actors in order to create, challenge, or reproduce a given set of rules. The skill required to induce co-operation, from one's own group and other groups, is to find collective meanings that motivate other actors. Skilled actors interpret the actions of others in the field, and on the basis of the position of their group, use their perception of current opportunities or constraints to attain co-operation; they engage in action because by producing meaning for others, they produce meaning for themselves. This view is supported by the argument put forward by Sewell (1992) in his theory of structure that seeks to restore human agency to social actors and overcomes the divide between semiotic and materialist visions of structure; Sewell's perception of agency (1992:21) needs to be quoted at some length in order to convey the complex strands of thought involved :

‘Finally, I would insist that agency is collective as well as individual. I do not agree with Barry Hindess (1986) that the term ‘agent’ must be applied in the same sense to collectivities that act as corporate units in social life-political parties, firms, families, states, clubs, or trade unions-as it is applied to individuals. But I do see agency as profoundly social or collective. The transpositions of schemas and remobilisations of resources that constitute agency are always acts of communication with others. Agency entails an ability to co-ordinate one’s actions with others and against others, to form collective projects, to persuade, to coerce, and to monitor the simultaneous effects of one’s own and others’ activities. Moreover, the extent of the agency exercised by individual persons depends profoundly on their positions in collective organisations. To take the extreme case, a monarch’s personal whims or quarrels may affect the lives of thousands (see, e.g., Sahlins 1991). But it is also true that the agency of fathers, executives, or professors is greatly expanded by the places they occupy in patriarchal families, corporations, or universities and by their consequent authority to bind the collectivity by their actions. Agency, then, characterises all persons. But the agency exercised by persons is collective in both its sources and its mode of exercise. Personal agency is, therefore, laden with collectively produced differences of power and implicated in collective struggles and resistances.’

According to Fligstein (2001), ‘institution building moments’ occur when groups of social actors confront one another in some set of social interactions that is contentious. These moments are inherently political and involve struggles over scarce resources by groups with varying power. There are a number of ways stable institutions can be built. Some groups come to dominate and impose a set of rules and relations on other groups. An outside force, such as a government (which itself is made up of fields), can enforce order, and privilege itself or its most favoured groups. Sometimes groups can produce a political coalition to bargain an outcome that provides rules for those groups. It is important to recognise that institution building may fail: disparate interests and identities of groups can prevent stable institutions from emerging. Fligstein suggests that (contrary to the rational choice view) actors’ preferences are not fixed, but can be endogenous to the process of institution building episodes. Put simply, people figure out what they want as events unfold (Fligstein, 1998, 2001).

Fields can go into crisis as a result of external changes, particularly in other fields that a given field is dependent upon. Thus, a downturn in a field’s major market or supplier, or in the case of governments, war or economic crisis, will have consequences for a particular local order. Crises can be caused by the intentional or unintentional actions of governments. One can identify a real crisis in an existing field as a situation where the major groups are having difficulty reproducing their privilege

as the rules that have governed interaction are no longer working. Skilled strategic actors in dominant groups will begin in a crisis situation by trying to defend the status quo. Challengers may find a political opportunity to force changes on the existing order. They may ally themselves with other dominant groups, invaders from other fields, or the government to help reconstitute a given field (Fligstein, 2001).

According to Fligstein (2001), the theory of social skill informs the way that we study the formation, stability, and transformation of new fields. In considering the implications of the theory for empirical research, he suggests there are two problems that one must solve to make the idea of social skill empirically useful. First, one needs to specify what sort of tactics real socially skilled actors use to induce co-operation. This will enable empirically oriented scholars to recognise who socially skilled actors are and to look for various tactics they might use to get co-operation. Then, one needs to connect the use of these tactics more closely to where actors stand in fields.

Fligstein gives several specific examples of tactics used by skilled actors. A major source of framing is having direct authority to tell someone what to do; but even with such authority one must still induce co-operation in subordinates, which requires a repertoire of other tactics to structure interactions with those within and across groups. Very briefly these include (Fligstein, 2001:114-115): agenda setting; understanding field ambiguities and uncertainties and working off them; convincing others that what they can get is what they want; brokering rather than blustering; pressing for more than one is willing to accept; appearing hard to read and without interest in personal gain; where the problem is to find a way to join actors or groups with widely different preferences, creating a common collective identity so as to get enough on board and keep a bandwagon going so that others will follow; having lots of balls in the air; getting others to believe that others are in control; and making alliances with people with few other choices, and isolating particularly difficult outliers.

When one is looking at the emergence or transformation of an existing field, the theory of fields implies that one must identify the main collective actors, their resources, and the rules that guide the possibility for action. Social skill implies that in fluid situations some actors will try to put together alternative institutional projects

to organise the field. According to Fligstein the goal of the analyst must be to identify the main possible projects and who their proponents are. By tracing how the proponents of these possible institutional orders framed their projects, modified them to make them more attractive to others, and basically built political bandwagons around them, the analyst can attempt to see how groups of institutional entrepreneurs produce new orders. (Fligstein, 2001)

The analyst can also become sensitive to why some frames win and others lose. It might be the simple case where the groups who align themselves around a particular frame are sufficiently powerful that they are able to push that frame on all of the other groups in the field. In other words, pre-existing rules and resources might be enough to explain which frame conquers. Alternatively, frames might be blocked, with no frame emerging as a way to organise a field, because skilled actors were not able to overcome potential veto points in the process. Finally, skilled strategic actors may be able to produce a frame that actually reorganises group interests by finding ways to create agreements by getting groups to change their conception of their interest (Fligstein, 2001).

Fligstein suggests a number of obvious methodological implications of the theory of fields and the idea of social skill. Analysts should spend time looking for entrepreneurs and examining their tactics: how do they spread their ideas, build political coalitions, persuade others, and create new identities? Moreover, can we observe them reorienting their framing? And to whom are they appealing by taking what the system gives, figuring out how to get others to co-operate, and figuring out who to co-operate with? Fligstein argues that scholars must understand who the players are in a field, how it works, and what are the tools available to skilled strategic actors to reinforce the status quo. Actors will use the tools that hold the status quo in place in a crisis. They will first deny that there is a crisis. If this fails, they will undertake actions designed to reinforce their power in the field. Finally, they will undertake piecemeal reforms or small changes that will leave the underlying power distribution in the field intact while trying to co-opt the opposition or challenger groups (Fligstein, 2001).

Fligstein concludes that the idea of social skill offers us a way to begin to study how actors sometimes can transform social structures, but most of the time fail to do so. It allows us to make sense of how resources and rules, once in place, tend to favour the biggest and most organised groups. The theory of fields helps us see that once in place, generally, dominant organisational arrangements reproduce themselves on a period-to-period basis. They do so because of a distribution of rules and resources toward dominant groups and the ability of skilled actors to use these to reproduce their power. That said, the reproduction of the power of groups is not always certain. There are always challengers to any given group's social power. Moreover, the basis of a group's power, its claim over resources and rules, can be undermined by periodic social crises. These crises can have their origin from outside the field or within the field. As these crises intensify, the role of skilled social actors in the reproduction of a given set of social power increases (Fligstein, 2001).

The concepts developed by Fligstein outlined above are useful in the study of mergers and will be used to augment and complement archetype theory for the purpose of this thesis. Although Fligstein's research was based upon change in private corporations, many of these companies' histories covered periods of merger activity, which will also provide some valuable insights into public sector mergers.

## **2.9 Summary**

The theory of organisational structure that underlies the archetype perspective seeks to overcome the duality of structure and agency. Structures are seen as a vehicle to reflect and facilitate meanings: they embody normative expectations and prescriptions for adequate performance. Power is a key analytical focus because it is the relations of power that enable some organisational members to constitute and recreate organisational structures according to their meanings. However, agency is - even in the case of powerful actors - constrained by contextual constraints

An archetype is a composition of structure and management systems given coherence and common orientation by an underlying set of values and beliefs as to what the organisation should be doing, how it should be doing it, and how it should be judged. More recent studies indicate that coherence can also be exhibited where alternative

archetypes (for example one based on professionalism and one based on managerialism) are 'sedimented', producing a hybrid form of organising. This may be a result of contemporary trends being reflected in fresh interpretive schemes, such as 'commercialised professionalism' or 'professional management'.

Archetypes originate in institutional fields. The concept of the 'organisational field' is central to institutional theory. Archetype transition may be analysed at the level of an individual organisation or across an organisational field, in the latter case giving the opportunity to understand the horizontal and vertical relationships and interactions between organisations in a particular sector, for example the hospitals and other health care organisations in a given locality.

Archetype theory provides a framework to enable an analysis of the scale, pace and linearity of change using the concept of 'tracks'. Four prototypical tracks (inertia, aborted excursions, transformations and unresolved excursions) were theorised but recent studies indicate the possibility for other tracks; tracks of change should not be seen as predetermined and are to be discovered through empirical investigation.

In archetype theory the dynamics of organisational change and stability are understood by analysing the ways in which organisational group members react to old and new institutionally derived ideas through their existing value commitments and interests and their ability to implement or enforce them through their existing power and capacity for action. The focus is thus on intra-organisational relationships and interaction. In a study of hospital mergers this is useful for analysing the internal restructuring process to implement the merger, but is too limited for analysing the negotiations, consultations and other interactions between the merging organisations and other actors in the field (including powerful government agencies) that take place in the period leading up to the merger. Fligstein's perspective on power and the state, and his microfoundational theory of social skill is particularly useful in this respect.

Fligstein notes that rational adaptation, resource dependence, and population ecology all assume that the environment is a fixed hard constraint on organisations. Political and institutional theories pursue the notion that resource dependence is socially constructed, leading some scholars to focus more on how firms constructed or enacted

their worlds. Fligstein has created what he calls a political-cultural approach, which posits that the basic problem facing organisational actors is to create a stable world so that the organisation can continue to exist. This calls for the construction of an organisational field in which actors come to recognise and take into account their mutual interdependence: these understandings are reached through political processes. Generally, the largest organisations develop a collective way to control the organisational field and they impose it on the smaller organisations. There are two problems involved in creating a stable organisational field: finding a set of understandings that allow a political accommodation in the field, and the legitimisation of those understandings by governments. Fligstein calls such a set of understandings a conception of control

From this perspective, states are implicated in all features of organisational life. The organisations and institutions of the state make and administer the rules governing economic interaction in a given geographic area, and they are prepared to enforce those rules, in the last instance through force. The state's claims to set the rules for economic interaction is social in origin, and as such it is contestable. The process by which these rules are set up, transformed, and enforced is therefore an inherently political process. Therefore the local politics and existing practices of nations will have profound effects on the form, content, and enforcement rules in organisational fields. The formation of organisational fields will depend on the politics in the field and the relation between the field and the state

Fligstein observes that although social theory is always concerned with the relationship of agency to social structure, it has not focused on the nature of the skills that social agents employ. Fligstein provides a theory of social skill that draws on ideas from symbolic interactionism. Fligstein starts with the new institutionalisms' common acknowledgement that action takes place within the organisational field (by whatever name this is called), in which social groups contest their respective interests. He describes the social skills used by an institutional entrepreneur (or 'skilled actor') to negotiate the interactions between powerful and powerless groups within the field to induce co-operation and arrive at a set of rules governing future relationships. Social fields tend to be stable and opportunities for skilled actors to bring about change tend to emerge in periods of crisis, especially when the field is being invaded



by some other (challenger) field. In these situations, the skilled actor can employ a wide range of interpersonal strategies, always appearing community-minded (whether he is or not) and unmotivated by personal gain, to manipulate rules and balancing off constituencies.

Fligstein describes several examples of social skill such as agenda-setting, brokering, and isolating opponents. Having thus mediated the establishment of new rules, the skilled actor must once again stabilise the field by instilling a new set of behaviours in the members of the field. However, the skilled actor's attempt to institute a new order can fail.

## CHAPTER 3

### METHODOLOGY: A LONGITUDINAL COMPARATIVE CASE STUDY

#### 3.1 Introduction

The researcher will be conducting a longitudinal comparative case study on hospital mergers in England and Ontario and will examine the organisational impact of this change process. When the research question seeks to examine organisational change over time it is important that the methodology provides a framework that can track and explain the unfolding temporal processes of change. Van de Ven and Huber (1990:213) have endorsed processual studies stating that:

“Processual studies are fundamental to gaining an appreciation of dynamic organisational life and to developing and testing theories of organisational adoption, change, innovation and redesign.”

The longitudinal case studies that are produced under the processual framework generate an abundance of rich data. The dynamic inductive –deductive interplay highlights how there is never a clear division between data and theory.

In this study the researcher will be seeking to track the merger process, identify key events, determine what factors affect these events, focus on the role of key strategic actors and groups of actors and then establish how all these elements come together and impact on the merger outcome from an organisational perspective. In most studies the links and patterns that emerge in the case are complex (Pettigrew, 1990; Langley, 1999; McPhee, 1995; Leonard-Barton, 1995 and Eisenhardt, 1989). Theory will be used as a framework for analysis rather than deriving some formal set of propositions that are to be tested through the case study, thus the development of theory is dependent upon and draws from the results found in the study.

The researcher will use multiple methods which will include the analysis of documents and archive data, the use of in-depth interviews and the collection of observational material. The major benefit of carrying out research over time that uses a range of different methods is that it allows for cross validation of the findings and enables the modification of research strategies in the collection of further data (Green

et al., 2005). The case study narrative is central to the analysis and its purpose is to seek a more critical understanding of the change process by accommodating multiple perspectives. The inductive theory building process that takes place during the data analysis and narrative development is key when examining the patterns in the data.

The researcher will reflect on the role of the researcher, address issues around case selection and gaining access to the research site, discuss the sampling strategy for the study, provide examples of how the data was analyzed and finally highlight issues pertaining to internal validity and reliability.

### **3.2 Justifying the Comparative Case Study Design**

A case study is a detailed investigation or history of a past or current phenomenon (Pentland, 1999). As a research strategy, it allows the researcher the flexibility to track change over time, as a response to contextual pressures, and the dynamics of various stakeholder groups in proposing or opposing change (Hartley, 1994; Stake, 1995 and Creswell, 1994). In this study the hospital mergers take place over an extended period of time and involve numerous hospitals, community organisations, actors and groups of actors. Case studies are useful when exploring new areas of research, building theory, tapping into informal behaviour, exploring social processes as they unfold in organisations and providing detailed data essential for cross-national comparative research. The case study's unique strength is its ability to deal with multiple sources of evidence which is crucial when studying a topic as complex as hospital mergers (Yin, 1994; Haspeslagh and Jemison, 1991).

A case study will often draw on a range of perspectives and methods with a collection of longitudinal data over periods of real and retrospective time (Pettigrew, 1985). However, as a research method, it cannot be defined through research techniques. Rather, it has to be defined in terms of its theoretical orientation (Pettigrew et al, 1992; Van de Ven and Poole, 1995; Dawson, 2003, Scott, 1994; Peterson, 1998 and Langley, 1999). The emphasis in this research is on understanding processes alongside their contexts. Therefore the intent of the study and analysis is to develop a finely detailed understanding of the change processes in order to develop theory,

rather than to test existing theories or propositions. The purpose of using a theoretical framework is to help the researcher formulate their research strategy, establish some basic criteria, inform the sampling process, guide the data collection and provide a framework for analysis. (McNulty and Ferlie, 2004; Hartley, 1995 and Pettigrew, 1995)

### *Comparing Cases*

The reason for studying multiple cases is to see if the change processes and outcomes across cases are due to transient events or to more static factors, such as government policy. The longitudinal nature of these cases meant that there is a sequence of ordered information about each case, within which both internal and external comparisons could be drawn (McPhee, 1995). Cross-case comparisons also have diagnostic value because they can reveal some underlying root causes of case difference and similarity. The comparative method is perhaps the best approach for generating and evaluating cross-national studies, because the subject matter and cases cover a wider range than in studies restricted to one country and this allows researchers to evaluate the limits of their propositions (Van de Ven and Poole, 2002 and Eisenhardt, 1989). The case oriented approach considers the case as a whole entity; looking at configurations, associations, causes and effects within the case and only then turns to comparative analysis.

Multiple cases are helpful in both generating explanation and testing these propositions systematically. The single case is subject to limits in generalisability and several potential biases which can lead to misjudgement of the actual representativeness of a single event. Multiple cases can strengthen the precision, external validity and stability of the findings. (McPhee, 1995; Yin, 1994; Green and Thorogood, 2005) The choice of cases is usually made on conceptual grounds not on representative grounds.

The case study method has been described as a valuable and useful approach for supporting theory development, achieving high conceptual validity and assessing causal mechanisms and complexity. (Eisenhardt, 1989; Miles and Huberman, 1994; Green and Thorogood, 2005) Case studies explore the operation of causal mechanisms in individual cases in detail. Many of the variables that interest

qualitative researchers are notoriously difficult to measure such as power, the political behaviour of the state and the social skill of the key actors, which will be the focus of study in this research.

### ***Limitations of Case Study Design***

However there are limitations with this research strategy as well. Two of the most common critiques of case study methods are that of case selection bias and the inherent limitation of making generalisations that apply to broad populations. (McNulty and Ferlie, 2004) Case study researchers sometimes deliberately choose cases that share a particular outcome and for some studies this is appropriate. In these situations, this can help identify which variables are either sufficient or not necessary to influence the selected outcome. Case studies may uncover or refine a theory about a particular causal mechanism such as collective social action dynamics that can be applicable to vast populations of cases but usually the effect of such mechanisms differ from one case context to another. Therefore it becomes difficult to render judgments on the representativeness of particular cases in relation to the wider population and it is important that the researcher points out that they seek only contingent generalisations that apply to the subclass of cases that are similar to those under study (Miles and Huberman, 1994, Broadbent and Laughlin, 2005). Again it is important to emphasize that case study researchers are more interested in finding the conditions under which specified outcomes occur and the mechanisms through which they occur rather than uncovering the frequency with which those conditions and their outcomes arise.

### ***Process Analysis***

The focus of analysis in case studies is on interpretation rather than quantification. Process analysis or tracing is a methodological approach which is often used to complement the case study approach which can be described as a qualitative data sampling and collection framework (Hornby and Symon, 1994).

Process analysis has a fluid character that spans time and space and draws on vertical and horizontal levels of analysis and the interconnections between those levels

(Langley, 1999; Leonard-Barton, 1995; Zaheer et al, 1999 and Eisenhardt, 1989). This model of analysis is particularly suited to the study of hospital mergers and change in the health care sector. The vertical level of analysis will refer to the interdependencies between the state, the organizational field and the actors (or groups of actors) involved in the merger process. While the horizontal level of analysis will focus on the sequential interconnectedness of the events that take place during the pre merger and early merger time periods.

Process analysis involves breaking down the data into various components, then locating data under one or more categories and sub categories before building connections across the research material as a whole. The process had been described by Dawson (2003:114) as:

“...the data is cracked open, labelled and then reconstructed to form something quite different from the original text, in an attempt to explain and understand the object of the study”

In other words, the researcher is decoupling, classifying and recombining data to develop, and redefine the concepts which have emerged from the cases. This data analysis process guides the researcher towards case write up, as an analytical chronology, in which patterns in the data are further identified and clarified (Pettigrew, 1995). The central aim of the narrative is to weave an argument that constantly moves from the general to the particular by linking the theoretical and empirical findings across the cases.

### **3.3 Developing a Theoretical Framework**

Theory shapes the case study research process. Case studies tend to explore and probe in depth the particular circumstances of the organisation and the relationship between organisational behaviour and its specific context (Pettigrew, 1992; Van de Ven, 1992; Yin, 1994). Therefore, the case study approach is more flexible and adaptable when it comes to probing areas of original but also emergent theory.

Although case studies may begin with rudimentary theory, as the case unfolds a theoretical framework should also evolve which not only informs and enriches the

data but also reinforces the importance and relevance of the case findings in relation to theory. Working with a theory has the advantage of sharpening and focusing the data collection and analysis. Van de Ven and Poole (2002) advocate the use of two theories because this approach gives the researcher an alternative option and reduces the likelihood that the researcher will try and make the data fit one particular theory.

The aim of this research is to develop process rather than variance theory: that is the researcher is interested in “describing and explaining the temporal sequence of events” involved in change rather than identifying relationships between variable levels of inputs and outputs. Thus, the case study method, which involves tracing processes in their natural context is most appropriate (Pettigrew, 1992, Van de Ven and Huber, 1992; Yin, 1994)

Hinings and Greenwood’s (1988) work on the dynamics of strategic change in local government was very influential in the way in which the researcher framed the study (deductive step). Their notion of organisational archetypes and change tracks appeared to be promising concepts for understanding healthcare change. Since the researcher was interested in developing an understanding of the processes involved in hospital mergers and focusing on these dimensions of organisational change, it was decided that it would be useful to deductively draw on archetype theory and extending it to the study of hospital mergers. However, as the study progressed, other observations were emerging from the data which were not adequately addressed in archetype theory (inductive step). It was noticed that many of the activities and events in the organisational field surrounding the merger process were influenced and directed by both powerful and skilled strategic actors. At this juncture in the study, the researcher returned to the literature and began to look at previous work on mergers and the role of power and actors in search of theoretical ideas that would help conceptualise what was happening in the cases. Neil Fligstein’s (1990) work on the importance of power and the role of actor(s) in organisational change was immediately appealing and appeared useful to further develop the researcher’s understanding of how mergers evolve. Fligstein (1990:311) stated:

“the ability to change large organisations depends on a complex set of action, both internal and external to the organisation and it is both the

ability and power base of individual actors and groups that can affect organisational actions and outcomes.”

Therefore the approach used in this study was partly deductive (data inspired) and partly inductive (data inspired). Denis, Lamothe and Langley (2001:812) conducted a similar study on the dynamics of collective leadership and strategic change in healthcare organizations in Canada and they found that:

“this mixed approach can be very fruitful because it allows one to gain creative insight from the data, without necessarily denying or reinventing concepts that have been useful previously and by relying on multiple and sequential case studies, one can also use deductive and inductive logic iteratively to foster the development of a richer theoretical framework over time.”

### **3.4 Conducting Research in Real versus Retrospective Time**

Longitudinal case data can be obtained by observing the sequence of change events as they occur in real time or by relying on archival data and interviews to obtain a retrospective account of the change process (Van de Ven and Poole, 2002). Real time studies can increase the internal validity by enabling the researcher to track cause and effect. However, in order to observe critical events the researcher must spend an inordinate amount of time in the field on site and in building relationships with the people involved. This approach requires both organisational commitment over the long term and the financial resources to support this type of research. One of the limitations of conducting research in real time is the research may lose objectivity. This can happen should the researcher become too involved with the organisation, the people and the processes (Miles and Huberman; 1994)

Retrospective studies have the advantage that there is an existing knowledge of the big picture, of how things developed and of the outcomes that ensued (Leonard-Barton, 1995 and Van de Ven and Huber, 1990). This post-hoc knowledge is helpful for interpreting the events that unfolded, and for constructing a narrative of the process. Although it may be easier for the researcher to maintain both in appearance and in fact an appropriate open mind, it is still difficult to determine cause and effect from reconstructed events. Studies have shown that participants don't forget key events but the problem is that they may not have recognized an event as important when it



occurred and thus may not recall it afterwards (Pettigrew, 1995) Therefore the researcher has to work hard at gaining access to a range of informants who can both corroborate and refute accounts of the process and since there is more reliance on self reporting the need to check these accounts against other sources of data are even more crucial.

Regardless of *how* and *when* the data is collected the researcher is the underlying link and by virtue of the research design they become part of the process of producing the data and its meanings. Therefore it is important that the researcher reflects on the possible sources of bias and how the role of the researcher can influence their interaction with informants, the data collection process and the analysis.

### **3.5 Understanding the Role of the Researcher**

When undertaking qualitative researcher it is important to acknowledge and reflect on the role of the researcher and the impact this may have on the study.(Green and Thorogood, 2005; Miles & Huberman, 1994; Pettigrew, 1995 and Creswell, 1994) This will include examining the past experience of the researcher and how this lead to the selection of the research topic and sites; the political and social implication of conducting research in these settings; the ways in which the researcher's presence on site could effect the study; the interactions between the researcher and the informants and finally, the ways in which the research site could influence the researcher.

#### ***Past Experience of the Researcher***

The researcher has worked in the healthcare arena and acute care sector in both Canada and Britain for over 20 years. The positions held have spanned frontline service delivery to senior management. During the last 10 years, the researcher has experienced first hand the chaos of restructuring, the complexity of mergers and the short-sightedness of radical service reform. As a result, the researcher became interested in developing a better understanding of how the merger process evolved in the acute care sector and what system and structural changes would result in hospitals. It was timely for the researcher that both countries were undergoing radical healthcare reform and that the governments were politically promoting mergers as a cost saving

exercise. This present situation coupled with the researcher's work experience, professional contacts and in-depth knowledge of both healthcare systems was an excellent opportunity to conduct a comparative case study.

### ***Social Implications and Political Alignment***

This research study was not funded or commissioned by any external research or government body. Therefore there were no hidden agendas or specific directives about the focus of the study; the kind of data that should to be collected or any publication restrictions, other than the agreement made between the hospital Boards and the researcher. The researcher recognised that the access granted by the participating hospitals and other healthcare organisations and groups was a privilege and with that privilege comes the scientific and ethical responsibility to present all significant views before offering the researcher's perspective. The researcher's main focus was on balancing detachment and involvement and on being cautious not to over identify with any particular actor, group or interests being presented.

When the researcher started the site visits and interviews the first task was to clearly articulate who she was, why she was there and what would be done with the information that was being collected. If you fail to do this from the onset, your presence will soon be defined by others in the settings and this could politically and professionally undermine the research. When settings have multiple groups with conflicting interests, the research always runs the risk of inevitably being perceived as being aligned with one group over one another. Once this association has been made, this can be extremely difficult to alter the definition of your role. (Pettigrew, 1995)

The fact that these studies were conducted retrospectively and the events were now part of the organisations' history, actually worked to the researcher's advantage. In the English case the researcher may have had difficulty accessing informants, conducting interviews and viewing any documents because of the conflict and political tension between the groups of actors. It is also questionable, looking back on this case, if information would have been so freely shared at that point in time. This wasn't a problem in the Ontario case because of the level of cooperation and consensus between groups. On the other hand, the researcher was aware that there

could be potential hindsight bias which can be associated with interviews that occur long after an event has taken place (Lawrence, Malhotra and Morris, 2005). Therefore care was taken in the interviews to clarify the events that lead up to any major decisions regarding the merger and to clarify the informants' political position, role and organizational alliance at the time of the merger.

### ***Researcher's Presence on Site***

In order to understand the impact of the researcher's presence at the research sites, it's important that the role of the researcher is clearly defined and the methods of data collection are described. The sources of data included document analysis, interviews, direct observation and informal conversations. At no time did any of these methods of data collection disrupt the functioning of the organisations, distract the staff from carrying out their roles or require the researcher to take on the role of participant observer. The researcher spent a substantial amount of time looking for and reviewing documents. As a result, the researcher kept a low profile and was situated in either the hospital library or a vacant office. *Social chat* usually took place with personal assistants to senior level management, the staff responsible for archiving the organisational documents and reports and informal lunches with various other healthcare professionals.

The senior and middle management levels of the organisation were sent a memo from the CEO's office informing them about my research and that some members of staff would be approached to participate in the study. It is also important to remember that research activity was common place in both of these teaching hospitals so having a researcher present was not an anomaly.

### ***Interaction Between Researcher and Informant***

As a researcher you need to have multiple skills when conducting field work. The researcher's first task is to contact the "senior gatekeepers" of each organization. This requires establishing rapport with the CEOs, selling the research proposal and demonstrating in the interview that you have both the social and political skills necessary to develop and maintain credibility with a wide range of senior executives

and healthcare professionals across the organisation. This was the researcher's first point of contact in each case and the first step in gaining access.

In the Ontario case, the researcher was introduced to the CEO through a mutual colleague, whereas in the English case, contact was established through the researcher's own initiative or cold calling approach. Due to the focus of this study, a majority of the interviews were conducted with those who were relatively more powerful and senior to the researcher. All of the senior leaders, clinicians and managers approached for interviews accepted the researcher's invitation. The researcher found that all of the informants interviewed gave 1-2 hours of their time and readily shared their personal and professional views of the merger, insights into the various events and details about the roles of key actors or groups of actors.

The key to good interviewing practice is to build a sense of trust with the interviewee to encourage disclosure. Once rapport is established the interviewee feels safe to answer questions and participate in the interview (King, 1994). The researcher obtained rich and detailed information from all of her interviews.

### *Effects of the Research Site on the Researcher*

The researcher has worked in hospitals for many years and as a result may tend to underplay some aspects of the context because of her familiarity and comfort with the setting. Therefore a conscious effort was made on the part of the researcher to acknowledge those feelings and thoughts about hospital dynamics and politics and to examine the activities of the informants in a more critical light within a conceptual and theoretical framework versus a more collegial perspective.

## **3.6 Research Design**

Research design encompasses several activities. The researcher needs to decide which organisations will be included in the study and what criteria will be used for case selection. Establishing hospital contact and gaining access for research purposes is a complex and time consuming process. It is important at the onset of the study to establish timelines as this is an important point that needs to be negotiated upfront

with the research site. Finally, the researcher needs to be clear on the sampling strategy.

### ***Case Selection***

In this study, cases were selected based on their comparability. In Chapter 4, the researcher highlights both the similarities and differences across the English and Ontario healthcare systems to show the comparability of the two cases. These cases were evaluated under the following headings: healthcare system classification, funding systems, guiding principles and belief systems, system structure and government processes and healthcare reform policies. The cases were narrowed further according to other relevant characteristics, such as merger activity, number of hospital sites, university affiliation, acute care service provision and merger time frame, which will further strengthen the comparability and increase the confidence in the findings across the cases (Miles and Huberman, 1994; Pettigrew 1995).

The criteria used for case selection is highlighted below:

- (a) *Merger proposal* – as a key criterion this meant that a merger had either been officially proposed or had already taken place.
- (b) *Teaching hospital status* – this meant that the hospital had both an academic and research affiliation with a university medical school. All the hospitals in this study had teaching hospital status.
- (c) *Multiple hospital sites* – this criterion relates primarily to the size of the hospital. Prior to any hospital change, each hospital was responsible for the management of at least 2 hospital sites. This meant that the hospitals were matched for cross-site restructuring and service integration.
- (d) *Range of medical services, with more than 600 beds* – this criterion relates to the size and service focus of the hospital. The hospitals in both cases were well matched. The Ontario hospitals had bed counts that ranged from 620 to 759 while the English hospitals had bed counts that ranged from 650 to 779. The hospitals in both cases were classified as general acute care institutions and offered a similar range of medical and specialty services
- (e) *Timeframe for change was between 1992 and 1996* – this criterion corresponded to my research timeframe and also the corresponding fifth wave of mergers.
- (f) *Organisational support* – it was imperative that the researcher had the support of

each hospital CEO and hospital Board. This level of support was necessary both for access and for the credibility of the research study. This support would need to cover the entire period of observation and data collection by the researcher.

This information can be referred to in Table 3.1: Comparative Hospital Statistics for the English and Ontario Merger Cases.

### *Establishing Case Contact*

The Ontario research site was contacted first. The researcher knew a senior member of staff at the Hamilton Civic Hospital and was introduced to the CEO. This initial meeting took place during the pre-merger consultation phase. The researcher was able to start her initial interviews and document analysis at the Hamilton site for a short period of time before returning to England to find a comparable English research site. At that time she was able to conduct 12 interviews.

The interviews conducted during this pre-merger phase were particularly useful in familiarising the researcher with local political issues, the hospital organisations, the senior management teams and the local government bodies. These initial contacts were important for establishing a data baseline on the targeted hospitals' structure and systems, the key actors, community actors and groups, the activity taking place during this pre merger phase and the initial government involvement around the reform agenda. The insight gained from the various actors and community groups were especially useful in understanding the dynamics that would evolve between these actors at a later date. Many of the hospital actors interviewed during this period left their respective organisations, so these initial interviews were very important because these actors provided valuable information that would have otherwise been inaccessible.

**Table 3.1: Comparative Hospital Statistics for the English and Ontario Merger Cases**

**PRE-MERGER PHASE**

Cases	Hospitals	Beds	Staff			Budget	Fiscal Deficit / Surplus	Clinical Programs	No. of Sites
			Medical	Nursing	Total				
British Merger	RV1	779	275	1250	2974	£85m	-£2.1m	16	4
	NGH	650	262	984	2285	£67m	+£2.8m	12	4
Canadian Merger	CMH	620	1087	Not Available	3899	\$217m	-\$10.5m	5	2
	HCH	759	990	Not Available	4120	\$236m	-\$1.5m	13	2

**POST MERGER PHASE**

Cases	Hospitals	Beds	Staff			Budget	Fiscal Deficit / Surplus	Clinical Programs	No. of Sites
			Medical	Nursing	Total				
British Merger	RV1	1540	581	2777	5875	£163m	+£0.7m*	9	2
Canadian Merger	HHSC	1507	Not Available	2400	7900	\$478m	-\$27m	18	7

Source: Newcastle General Hospital Application for NHS Trust Status. April 1993;

RV1 Annual Report and Accounts, 1993/94;

RV1 Annual Report and Accounts, 1994/95

CMH & HCH Proposed Merger Report of the Transition Committee, June 1996;

HHSC Financial Statement, March 1997;

HHSC Operating Plan for the fiscal Year 1997-98, August 1997

\*This figure was adjusted from a £30m deficit to a £.7m surplus because of the PFI scheme.

The researcher would return to Canada two years later to continue the rest of the data collection post merger. It should be noted that 7 of the 12 informants who were interviewed prior to the merger were also interviewed post merger. The data collected from these informants was particularly unique because they were able to compare their initial expectations on what they thought would be achieved through the merger to what had actually transpired over the 2 year period.

The researcher, after her first trawl for data in Ontario, returned to England and began the task of trying to find a suitable case match for the Ontario site. Unlike the Ontario case, the researcher did not have a collegial contact in England and had to use the “cold calling” technique for the English case. Five English hospitals were contacted and the CEOs interviewed to determine whether any of these hospitals would be a likely match for the Ontario case. Only one hospital qualified according to the criteria set out by the researcher. The researcher tried to find a hospital merger that was taking place in real time but unfortunately that was not possible. The merger in the English case had been completed and the hospital was now in the early post merger phase. Both these cases were matched according to the criteria established at onset of the study and a majority of the data collection was conducted retrospectively.

### ***Gaining Access to the Research Sites: Securing Board Approval***

As mentioned previously, the researchers’ first point of contact in each hospital was the CEO. At the initial meeting the objectives of the research study, the type of data that would be collected, the required organisational access and the time frame of the study was discussed. At this meeting the researcher was informed what the organisational expectation would be in relation to ethics approval and the responsibility of the researcher as a non-member of staff.

The ethics committees in hospitals and in local regions were primarily concerned with clinical research and many had little experience in judging the appropriateness of qualitative research. (Green et al, 2005) Therefore it was no surprise to the researcher when, in both England and Ontario, it was decided by the ethics committee to delegate the task of project review and approval to the senior management teams in the hospital. This decision was made on the premise that the criteria used in the ethics



committee to evaluate research projects was based on principles taken from medical research guidelines and, due to the nature and focus of this study, the committee felt it would be unable to evaluate the research protocol. Instead the researcher was asked to attend two senior executive meetings.

The first meeting would be with the senior executive team who would initially screen and review the project proposal and the second meeting would be with the hospital board who would decide whether or not the project would be approved. At both meetings the researcher was asked to submit a project proposal, make a formal presentation to the teams and answer questions pertaining to the study subjects and data collection. The focus of the discussion with the hospital boards pertained to hospital document access, the use of office space at the hospitals, how the data would be obtained during the interview and be secured (that only the researcher would have access to these tapes) and how the researcher proposed to address both informant and reporting confidentially. It was agreed, at the Board meeting, that the name of the participating organisations could be used in the thesis. This information was also shared with each individual who agreed to be interviewed.

Each prospective interviewee was contacted by telephone to arrange an appointment. The researcher had prepared a script and it was made clear during this conversation that their decision to participate was voluntary. The participants were given information about the research objectives, the purpose of the interview, the kind of data that would be collected and that every precaution would be taken to protect their identity (Creswell, 1994; Green et al ,2005).

### ***Establishing Study Timelines***

When undertaking a research project as complex and large as this study, it is important and necessary to set boundaries which help define the parameters of your study so you can manage and establish a working timeframe. When you are working across several sites it becomes a major challenge to track down hospital documents, identify and contact your interviewees and arrange time to meet with them. Therefore you need to give yourself a fairly large window of time. The researcher spent 5 months at each site (Miles & Huberman, 1994).

Therefore one of the first steps prior to data collection is to establish the data collection start and completion dates (Pettigrew, 1995). Both these timelines are justified and set according to the researcher's theoretical framework and the context of both cases. Since our focus was on studying the merger process and determining if there had been any change or emergence of a new hospital archetype, the logical start point was the beginning of the government mandated healthcare reform and restructuring legislation in both cases. In the English case, this was when the Royal Victoria Infirmary obtained its original Trust status in 1992 and in the Ontario case it was when the Ontario Government had established the Health Services Restructuring Commission in 1996 to lead the restructuring and healthcare reform agenda across the province.

The end point for data collection in both cases was the early post merger phase after the merger agreements were approved by the government and the hospitals were undergoing organisational re-design and service reconfiguration. This end point in the data collection allowed the researcher sufficient time to evaluate and determine whether a new hospital archetype would emerge as a result of the merger.

### ***Rationale for "Elite" Sampling***

Process analysis or tracing is a method of identifying and describing organisational processes across time and actor groups. The researcher is interested in building up a holistic picture of the merger process taking into account a number of different perspectives (across the organizational field) and experiences but from a knowledgeable group of informants (Dawson, 2003; Denis, Lamothe and Langley, 1999). The purpose is to identify those people who are *most* knowledgeable, have *access* to specific information about the merger due to their *position* in the organization (hospital) or the community (local healthcare agencies or groups) and who *attended* meetings which had a *direct bearing* on the outcome of the merger. Therefore sampling from senior leaders and decision makers in this study was important because any member from an organization below the middle management level would not have been privy to this kind of information nor would they have been allowed to participate in the meetings where major decisions were made about the merger. The researcher was not interested in obtaining personal or emotive views

from the frontline staff who would have obtained information about the merger second hand.

### *Sampling*

Archetype theory emphasizes the importance of understanding the situational constraints that are derived from the case context that can affect the change process. Therefore the researcher must be sensitive to the range of information and data that can and should be collected. This should include political processes, organisational arrangements and social alliances that existed between different groups of actors. These kinds of factors will influence and direct the sampling process.

The second step in the sampling process was to define the sampling parameters or data categories (Hornby and Symon,1994). The researcher started with three data categories. The first category focused on identifying the organizations and groups of actors that were involved in making decisions about the merger. The second category focused on tracking the key events and activities that led up to and influenced the merger. The third category focused on analyzing the role of key actors or groups of actors and the tactics they used during the merger activities. These three main categories of data would provide the sampling framework which would guide and inform the sampling process in the cases. In short, these parameters focused on the following: the setting, the organizations, the events, the actors and the processes. These parameters would in turn influence the choice of informants, the specific episodes and events studied and the kind of interactions that would take place between key actors and groups of actors that would be of interest to the researcher.

Sampling within cases has been described by Miles & Huberman (1994) as having a 'rolling' quality which alludes to the researcher working in progressive waves as the study progresses. This sequential and investigative aspect of analysing documents, observing meetings and interviewing a variety of actors in the research setting, continually led the researcher to new samples of informants, observation opportunities and documents. The researcher throughout the data collection period was constantly making sampling decisions to extend the area of information, clarify trends and patterns that had emerged in the data, qualify existing data, identify discrepancies and contrasts in relation to the interview data and to provide more evidence about another

theme that had emerged during her investigation (Green et al, 2005). The sampling information further consolidated the researcher's view of the local merger process, the contextual issues, the events that took place over time, the processes that were in place to support those activities and the actor and groups of actors who both influenced and were involved orchestrating the merger.

The theoretical framework and the sampling strategy are intrinsically linked. The theoretical framework establishes some basic criteria which the researcher uses to provide structure for the kind of information and data the researcher will collect. During this process, insights from one case generate constructs that serve as a basis for probing the merger process in the other case. It is the combination of deduction and induction through time and sequential sampling and analysis that provides the basis for the researcher's theoretical inferences.

The sampling strategy used in this study research is similar to what has been described in the literature as judgement sampling. Judgement sampling is where informants are identified in accordance with the interests of the researcher because they will shed light on a particular aspect of behaviour or activity under investigation (Hornby and Symon, 1994; Dawson, 2003). In this study the researcher searched for a specific group of relevant people who had inside knowledge about the merger, had access to information and had participated at the decision-making level. In ethnography studies opportunistic sampling is used whereby people are interviewed based on their availability and willingness to participate (Green et al, 2005). This approach would not have yielded the kind of data required in this study on hospital merger process. The deliberate selection of informants in this study was paramount and the on-going data collection process continued to drive informant selection over time. The major difference between this approach and theoretical sampling is that theoretical sampling is about generating theory, whereby the researcher collects, analyzes and decides what data or information to collect in order to develop theory as it emerges (Hornby et al, 1994; Pettigrew, 1995; Green et al, 2005). Judgement sampling is a broader concept and although theory may inform the strategy, it may also be informed by the researcher's experience and practical knowledge.

In theoretical sampling data is collected until a point of saturation is reached, when no new constructs are emerging. In process analysis, all key participants who have been identified in leading the merger process are included in the sample. For example, all the key actors who were involved in the Seaburn Workshop in the English case were interviewed. This method or approach to sampling is flexible enough to be applied both when the process can be tightly defined and for more loosely defined cases when the start and end points are less clear (Dawson, 2003; Hornby et al, 1994).

### **3.7 The Use and Analysis of Multiple Sources of Data**

The use of multiple sources of evidence allows the investigator to address a range of historical, attitudinal and behavioural issues. The major benefit of conducting research over time is that it utilizes a range of different data collection methods which allows for the cross validation of data. Therefore the findings or conclusion in the case study is more convincing and accurate when it is based upon several different sources of information (Miles and Huberman, 1994; Green et al, 2005). In this study the researcher included the use of in-depth interviews, an analysis of documentary and archival data, the collection of observational meeting material and informal conversations.

Organisational documents can provide factual information which is useful in constructing a chronology of key events, identifying key informants and directing the researcher to other relevant reports. In-depth interviews allowed the researcher to probe deeper to uncover new clues, open up new dimensions of a problem and to secure vivid, accurate and inclusive accounts that were based on personal experience (Burgess, 1982). The final approach used by the researcher was direct observation and informal conversations which covered a range of events in real time. All of these methods were used to collect data. .

#### ***The Use of Documents***

Archival documents were a useful source of information because these factual records provided historical insight into the merger process. Many of the documents were records of communication between key actors in the field about events taking place during the merger. These carefully crafted viewpoints which were intended for either

key actors or particular groups of actors were a very rich source of data. Access to confidential correspondence provided a useful record of contentious issues, however it is particularly important to avoid taking such documents at face value and to make some allowances for the audience for whom they were originally intended and the possible motives the author might have had in saying what they said (Reay and Hinings, 2005). It is important to note that from the interviews, the researcher was able to gain an understanding of the political and value-laden processes inherent in creating many of these documents (Forster, 1994).

Documents made up a large proportion of the data set. The researcher had access to board minutes and reports, business cases, organisational strategic plans, annual reports, trust applications, government reports, feasibility studies, consultation reports, collaboration agreements, newspaper articles and the merger agreements. A complete list of the documents used for the cases can be found in Appendix A and B. The documents collected from the hospitals were also an integral part of tracking change in the hospitals' systems and structures and mapping the integration and re-design of services during the post merger phase (Ventresca and Mohr, 2002). Senior executives prepared many of the documents and most of these actors were interviewed during the same period so accuracy and their authorship could be validated.

Finding the relevant information was a lengthy, time consuming process. The researcher often sat at a desk for weeks reading through binders and file boxes of documents. There was no one definitive source of information about the merger process. The information was found in different files across departments and hospital sites.

All documents were given a reference number; indexed according to country, document date was specified, the merger stage was identified and the full title of the document was recorded. All this information was entered into a database, which facilitated storage and retrieval. This data management system allowed the researcher to easily cross-reference any information on the database. The researcher had collected over 400 documents for both cases. The documents ranged from 2 to 300 pages in length.

## *Document Analysis*

The initial task in document analysis is to search for themes within each document and then clusters of documents. At this stage the focus of attention was on meanings rather than analysis. Each document was reviewed carefully and the viewpoint of the authors was cross referenced with other reports in that particular time period and around certain events. The researcher found that it was possible to cluster documents by authors or groups who shared the same viewpoints and interpretations of particular issues and problems that emerged during the merger process. Although documents may stand as sources of data in their own right, it is important to remember that this kind of data can only ever be fully understood within the broader organisational contexts and processes with reference to other forms of data (Forster, 1994).

Each document was read in its entirety and categorized according to which merger phase or time period it was written. The next step in the process was to identify which actor or groups of actors were responsible for this report and in what capacity did their viewpoint or actions impact certain events in the merger process. Documents were also clustered around certain key events. This analysis was particularly helpful in establishing how the merger process evolved, who were the key actors or groups and what role did they play in the merger. Documentary data was also used to develop a chronological record of events and formal positions taken by different groups.

Statements and quotes were selected from documents, for the case study, that appeared to show how actors or groups responded to particular events in the merger process, how the merger consultation process developed over time and what organisational and service changes resulted from the merger.

## *Conducting Interviews*

The purpose of the qualitative interview is to access 'accounts' from a group of informants about the merger process and to compare those 'accounts' against responses from other informants and other sources of data (Green et al., 2005; Miles and Huberman, 1994; Pettigrew 1994). It is important to remember that each account is valid as it is their own story of how the merger events unfolded. Pettigrew (1994:106) states that:

“the interview as a research tool probes beyond the “what of change” and gets into the subtleties of “why and how change happens.”

As an interviewer, it was important to distinguish between the informants’ descriptive evaluations of the ways things ought to be, their perceptions of the way things actually are and the way they feel others interpret their situation (Dawson, 2003). Clarifying the status of various statements is often a central analytical task in making sense of interview data. Discrepancies between the views of different groups of actors, especially during the merger consultation stage, weren’t seen as problematic but rather part of the rich data that is accessible through processual research.

The informants were a representative population of chief executive officers, director level executives, board chairs, medical staff, nurse managers and medical school academics. These senior people were selected for interviews because they had access to specific information about the merger because of their positions, were knowledgeable about a broad variety of changes both within and outside their organizations, and were directly involved in the merger negotiations. The researcher made sure that people from all hospital sites and the various community groups involved in the merger were represented in the sample.

All of the informants approached agreed to be interviewed. The sessions were tape recorded and later transcribed by the researcher. Each informant was assigned a random number and the transcriptions were anonymised. The content was analysed to identify themes and patterns across the data. The length of each interview ranged from 1 to 2 hours. The informants often suggested other colleagues that should be interviewed. The interview format initially had a low degree of structure and the questions were mostly open-ended and focused on specific situations and action sequences. But as the interviews progressed, the researcher imposed more structure so the information obtained was more consistent and easily compared across cases (Dawson, 2003; King, 1994 and McPhee, 1995).

In the Ontario case, a total of 42 interviews were conducted across 12 organisations. Of the 42 sampled, 12 informants were interviewed in real time prior to the merger and 30 were interviewed after that period or retrospectively. In this particular sample



group, 8 informants were interviewed twice, once during each of the pre-merger and post merger phases. In the English case 37 informants were interviewed across 13 organisations. All of these interviews took place retrospectively. Therefore in total the researcher conducted 79 interviews across 24 different healthcare and related organizations in both cases. The interview sample list of organizations and interviewee roles for the English and Ontario cases can be found in Figures 3.1, 3.2, 3.3, and 3.4. For continuity in data collection the same or similar role holders were sampled across the cases so comparisons might be drawn.

### *Interview Analysis*

In the interview the researcher attempted to trace the events associated with the merger, to identify the roles of key groups, to understand the logic behind the actions and to gauge the reactions of the informants to these events. The researcher used the three or four most important issues within the merger process as themes in structuring the interview questions (Denis, Lamothe and Langley, 2001).

All of the interviews were taped and fully transcribed. Before commencing analysis of the transcripts, the researcher thoroughly read through all the transcripts more than once and listened to the tapes and took into account nuances of speech, tone of voice, hesitations and other such paralinguistic information (King, 1994). The data and the analysis focused around key events and specific activities; processes such as the sequence of events and transitional turning points in the merger, and actor level dynamics which focused on interactions and power dynamics between key strategic actors and groups of actors.

The data and quotes taken from the interview transcripts were further analysed according to themes. This analytical process allowed the researcher to readily compare similar events, processes, descriptions and quotes across cases.

**Figure 3.1: English Case: Interview Sample by Organisation (N=12)**

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Royal Victoria Infirmary and Associated Hospitals NHS Trust	Newcastle and North Tyneside Health Authority
Newcastle General Hospital	Northumberland Health Authority
Freeman Hospitals NHS Trust	Sunderland Health Authority
Newcastle City Health Trust	Tynedale Total GP Fundholding Group
University of Newcastle Upon Tyne	Saville Medical Group (GP Fundholders)
North East Regional Office	
Newcastle Community Health Council	

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**Figure 3.2: English Case: Interview Sample by Roles (N=37)**

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	Directorate General Manager
Board Chair	
Chief Executive (6)	Head Architect for Planning and Re-development
Medical Director	Project Nurse
Director of Finance	Trade Union Representative
Director of Business Development	Ward Sister
Director of Corporate Planning	Head of Community Care
Director of Personnel	Director Community Services
Director of Nursing (3)	General Practitioner
General Manager	GP Practice Manager (2)
Head of Capital Finance	Business Planning Manager
Head of Performance Review	Professor , Medical School (2)
Clinical Directors (3)	Professor, Dental School
Directorate Head of Nursing (2)	

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**Figure 3.3: Ontario Case: Interview Sample by Organisation (N=12)**

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Hamilton Civic Hospitals	Hamilton Health Science Corporation
Chedoke-McMaster Hospital	Victorian Order of Nurses
St. Joseph's Catholic Hospital	Ontario Nursing Association
St. Peter's Hospital	Canadian Union of Public Employees
McMaster University	Health Service Organisation
Hamilton-Wentworth District Health Council	Health Action Task Force

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**Figure 3.4: Ontario Case: Interview Sample by Roles (N=34)**

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Board Chair	Director of Transition Planning
Chief Executive Officer (7)	Director of Finance
Executive Vice President & Chief Operating Officer	Program Director
Executive Vice President , Corporate Development	Clinical Manager (2)
Vice President, Research and Strategic Initiatives	Board Co-ordinator
Vice President, Community Health	Surgeon
Vice President, Regional Services	Professor, Faculty of Health Sciences (3)
Vice President, Program Support	Professor, Members of the Health Action Task Force (2)
Vice President, Speciality Services	General Practitioner
Chief of Medical Staff	GP Practice Manager
Chief of Professional Practice	Staff Nurse / Union Representative
Chief Human Resources Officer	Local Union President

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### ***Direct Observations***

The researcher was invited to attend board meetings, medical advisory committee meetings, middle management meetings, union meetings and community based meetings. This gave the researcher the opportunity to observe and record the behaviour of a variety of different groups of actors both internal and external to the hospitals. Observation was an ideal way to see directly how people align themselves politically during the merger negotiations and how the different actors interacted during critical junctures in the merger process. This data would then be compared with the information obtained in interviews and from hospital documents. The researcher used the material from the field notes as supplementary sources of data that was included in both the document and interview analysis.

### ***Informal Conversations***

Data was also collected through numerous informal conversations. While these conversations were not taped or transcribed, they yielded important information which was captured in the researcher's field notes.

The next step in the analysis would entail the development of a chronology which would provide a sequential analysis and mapping of the merger process over time and then the final step would involve the presentation of a detailed case study narrative and cross case comparison.

## **3.8 Developing a Case Chronology**

The development of the case chronology was a crucial step in mapping the key dates and events over the pre and post merger phases. Documents are often a good source of data for dates, numbers, events and actor identification. The main purpose of the chronology is to develop analytic themes. The researcher used four different categories or levels of analysis; these were the national or regional level of government; the municipal or local level of government and finally the hospital or

service level. The researcher wrote a detailed summary of the chronology and also mapped the events in a matrix format using a technique called visual mapping (Langley, 1999 and Pettigrew, 1990).

Visual mapping is a useful method for organising incident data. It can be described as a graphic diagram or other visual representation that permits the compact presentation of large quantities of information. It is particularly useful for analysing process data because it allows the simultaneous display of a large number of dimensions and shows precedence, parallel processes and the passage of time. This allowed the researcher to establish the temporal sequence of events and begin to map out the different pathways of change.

What are critical were not just the events but the underlying logics that gave the events meaning and significance. This kind of information was obtained through interviews. The researcher was able to establish links between the levels of activity and key groups of actors. The clusters of activity were often associated with coinciding political events at key times throughout the cases. What gradually emerged out of the data analysis was the importance of actors in effecting change and the way in which they use power to manipulate and direct change,

### **3.9 Case Narrative**

The case narrative is a descriptive story that is meant to help identify complex patterns and themes relevant to the merger process and to look at the theoretical propositions identified by the theory. The central focus of the narrative was to focus on underlying processes that give rise to certain events and to identify the actors whose actions tie these event together (Pentland, 1999).

Most activities were initiated by more than one actor and usually different groups of actors. A key question that was addressed in the case was ‘who does what?’ Therefore, the data concerning the identities and relationships of and between key actors and groups of actors was important in determining their roles and actions in the

process (Pentland, 1999 and Bourgoyne, 1994). The case narrative also focused on the power dynamics and politics as explanatory constructs.

The narratives for both the English and Ontario cases were written several times. When studying mergers, this change process lends itself to decomposing the chronological data from each case into successive discrete time periods or phases that become comparative units of analysis. Phase transitions are created by events, which means that events cause and prescribe phases and can even serve as break points (Langley, 1999). When placing the data into these temporal categories, it is important to distinguish between clock time and event time. This method is called temporal bracketing and many process studies adopt this approach.

### *Data Displays*

In the cases, the researcher has included numerous figures, flow charts and tables which support the narrative and provide a visual presentation of complex processes. The researcher has provided detailed flow charts mapping the hospital configurations before and after the merger, the stakeholder groups involved in the consultation and restructuring process and the re-configuration and re-location of clinical services across hospital sites. Organisational charts were also included to show the structural transition and re-organisation across the hospitals.

### *Cross Case Analysis*

The purpose of the comparative case method is to search for cross case patterns, draw out the subtleties of broad themes and theoretical developments across the cases (Eisenhardt, 1989; Peterson, 1998; Dawson, 2003 and Leonard-Barton, 1995). A technique used by the researcher was clustering. This method was particularly useful when conducting cross case comparisons. Clustering is a tactic that can be applied to events, processes and actors (Miles and Huberman, 1994). In the cases, the researcher identified crucial institutional building events that represented key turning points in the merger; at the process level, the researcher clustered groups of activities that took place during the pre-merger consultation phase and when focusing on key actors, the

researcher analyzed the tactics used by actors to influence other actors. These are just a few examples how this technique was used across cases.

This comparative case approach improves the likelihood of developing a more accurate, reliable study and also provides a platform for capturing novel findings that may exist in the data (Eisenhardt, 1989).

### **3.10 Internal Validity: Confirming the Findings**

Different methodological approaches were used in this study for several reasons. One was to add depth and richness to the data and to improve understanding and the other was to increase confidence in the validity of the findings. (Green et al., 2005; Miles and Huberman, 1994; McNulty and Ferlie, 2004, Lawrence, Malhotra and Morris, 2005) Throughout the field work and data analysis the researcher sought to assure high levels of internal validity by ensuring that the data obtained and transcribed was accurate, that the views of the informants were honestly portrayed in the case material, that the context rich case reflected the temporal sequence of merger events and that the data presented was linked to the theoretical constructs (Miles and Huberman, 1994). Data was collected from multiple sources and the use of triangulation provided important checks on internal validity. The researcher also sought data and case verification through informant feedback.

#### ***Triangulation***

Triangulation is about using different strategies for collecting data to improve the accuracy of that data. It is about providing another perspective on a particular phenomenon. The primary aim of triangulation is to offset the particular weaknesses of each method used and to challenge the biases that come from only one perspective (Yin, 1994, Eisenhardt, 1995, Hartley, 1994; Green et al., 2005). In this study the researcher uses three kinds of approaches; data triangulation, method triangulation and theoretical triangulation.

### *Data Triangulation*

In this study data is collected from a range of informants across numerous organisations. Each informant had a unique role in the merger process and many were positioned in opposing strategic groups. Although they offered different interpretations and perspectives on the merger process, there was consistent agreement on the actual facts of the merger events, activities, actors and outcomes.

### *Method Triangulation*

Multiple methods were used to collect data. The research analyzed archival materials and documents; conducted interviews, observed a range of meetings and engaged in corridor conversations. This material was able to verify many of the accounts provided by the informants in interviews.

### *Theoretical Triangulation*

This is when more than one theoretical approach is used to analyze the case material. The original theoretical framework used in this study was archetype theory but as the study evolved and the focus began to move away from intraorganisational dynamics to the role of external actors, it became evident that archetype theory could not address all the issues that were emerging from the data. This meant that the researcher would have to consider another theoretical framework that would complement archetype theory around the role of actors, the use of power and social skill to bring about change.

The introduction of a second theory meant that the researcher now had options regarding data analysis and interpretation. Therefore it was less likely that the data would be forced to fit one theory (Green et al., 2005).

### *Respondent Validation*

The most logical way to evaluate the outcomes of your study is to take the findings back to the participants. Green et al (2005:193) has referred to this as the ultimate mark of credibility when both the researcher's and the insider's point of view coincide. This exercise is really about confirming your findings with the experts in



the study. Stake (1976) has taken the view that case feedback is actually a quasi-ethical issue and that informants have the right to know what the researcher has found and from a confidentiality perspective informants may want to ensure that any reports are not going to damage their interests.

The researcher found this feedback structure, which was built into the study design, an opportunity to both share the results with a key confidant and a chance for the confidant to evaluate the accuracy of the findings (Miles and Huberman, 1994, Green et al., 2005, Denis et al., 1999; McNulty and Ferlie, 2004). This verification process was conducted three times during the course of the study. The first two were done with a neutral confidant, in the early and mid stage of data collection, who was not designated as an informant for interview purposes. The final feedback session was held after the final analysis with a few key informants who were interested in the findings and were prepared to scrutinize and comment on the results. An executive summary was also sent to the Board as a professional courtesy, an opportunity to comment on the findings and as agreed under the access conditions.

### ***Reliability***

Reliability refers to the 'repeatability' of the study which in qualitative terms refers to the likelihood that a comparable piece of research would yield similar kind of results. In cross case studies, replication is an important part of the basic data collection effort. In this study, the cases were matched (as closely as possible) and the study design, such as sampling, data collection methods, case analysis techniques and case study narratives were conducted in the same manner. The idea was that this new data would either bolster or qualify the original data collected and that emerging patterns from the English case would be replicated in the Ontario case (Yin, 1994)

### ***Conceptual Generalisability***

Generalisability refers to the extent to which findings from one study apply to a wider population or to different contexts. The findings in this research study are based on only two cases which were closely matched on a variety of criteria. However we cannot know for certain that we would find these dynamics of power and the role of

actors as influential in other sectors or in other time periods under the same circumstances. But nevertheless the researcher feels that the findings in this research study have produced insights and enhanced our understanding of the merger process in public sector hospitals. It is important to note that the claims from this research have been carefully constructed and the findings have been supported not only with empirical data but with theoretical logic. Therefore the researcher feels that this study has met the criteria for conceptual generalisability (Yin, 1994; Dawson, 2003; Pettigrew, 1990; Langley, 1999; Green et al., 2005)

### **3.11 Summary**

This chapter provides a detailed explanation of the methodological approach in this research. The primary purpose of this study was to conduct a longitudinal comparative case study on hospital mergers, using a processual approach to explain the interconnected and dynamic processes inherent in organisational change, through a detailed description of the events, the activities, the processes and the role of the actors and groups of actors involved in the merger process.

The research strategy of this study is discussed in relation to case selection, hospital fieldwork, data collection (using multiple sources of data) and case analysis. Due to the longitudinal nature of this kind of research on organisational change, it is necessary to have researcher commitment, management support, long-term access to the organisation and systematised data collection.

Cross case comparisons can reveal underlying root causes of case difference and similarity. The comparative method can strengthen the precision and validity of case findings and is perhaps the best approach of generating and evaluating cross national studies.

## CHAPTER 4

### THE COMPARABILITY OF THE BRITISH AND CANADIAN HEALTH CARE SYSTEMS

#### 4.1 Introduction

The purpose of this chapter is to establish the broad comparability of the British and Canadian health care systems. This is important because the focus of the research study is to compare hospital mergers from each country. The aim is obviously not to show that the health care systems involved are in all respects exactly the same, such that any variations in the two cases cannot be attributed to differences in the contexts. On the other hand, it is important to establish that the health care systems, and other features of the context, are broadly comparable. This is simply to give more plausibility to the argument presented here, that it was the processes involved in the mergers themselves that were the decisive points of difference between the cases.

Methodologically considered, case study research must include particulars of the context of featured cases (Yin, 1994; Stake, 1995; Hartley, 1994). As Miles and Huberman (1994:102) state:

“to focus solely on individual behaviour without attending to contexts runs a serious risk of misunderstanding the meaning of events”

In this instance, the salient contexts for the cases are mainly the political and administrative arrangements for the provision of health care in Ontario and England. Health care systems are provided within an administrative system in all economically advanced societies, so the relevance of this consideration is obvious. The political context is relevant in at least two ways: firstly, in both countries there is a political as well as an administrative allocation process through which the funding for the health care system is routinely provided. Secondly, there was a quite similar political crisis which precipitated the perceived need for various kinds of cost-savings in the health care system, including the need for hospital mergers. This political crisis occurred in very similar ways, for very similar reasons and at very similar times in both countries.

For the reasons given, it is important that this chapter highlights the political context, the funding system, the government structures and the reform agendas of both the English and Ontario healthcare systems. As discussed, the purpose of this comparison is to show in what way these systems are broadly similar. Each healthcare system will be compared under the following headings:

1. healthcare system classification
2. funding systems
3. guiding principles and belief systems
4. system structure and government processes
5. healthcare reform: systems in crisis

#### **4.2 Healthcare System Classification**

The health care systems of western developed countries in the Organisation for Economic Co-operation and Development (OECD) can be classified into three groups: the *National Health Service* or the *Beveridge Model*; the *Social Insurance* or *Bismarck Model* and the *Private Insurance Model* (Elola, 1996; Roemer, 1960; Contandriopoulos, 1993). These classifications are based on the predominant economic system and the entitlement to access to health care services. See Figure 4.1 below.

Britain and Canada's health care systems are both classified under the National Health Service (NHS) or Beveridge model. This model is characterised by universal coverage for residents, financing by national general taxes and some form of national ownership/control of service production (Auer et al. 1995; Murray, 2003). However, it should be noted that none of these categories are mutually exclusive but are based on the predominant type of health care system in each country. Different health care systems co-exist in most western developed countries. In those with an NHS there is usually a private health care subsystem (Elola, 1996).

In Canada, hospitals have public funding for their day-to-day operations but depend on private contributions for many of their capital programs. Hospitals are non-profit corporations governed by independent board of trustees, while the vast majority of

**Figure 4.1 Classifications of Different Types of Health Care Financing and Delivery Systems Used by the Organisation for Economic Co-operation and Development (OECD)**

<b>OECD HEALTH CARE CLASSIFICATIONS:</b>
<p>1. The <i>National Health Service</i> or <i>Beveridge Model</i> is characterised by universal coverage for residents, financing by national general taxes and some form of national ownership/control of the factors of production. Examples are the United Kingdom, Canada and Italy.</p>
<p>2. The <i>Social Insurance</i> or <i>Bismarck Model</i> is characterised by compulsory universal coverage within a social security framework, financing by employer and individual contributions through non-profit insurance funds and a combination of public and private ownership of the factors of production. Examples are Germany and France</p>
<p>3. The <i>Private Insurance Model</i> is characterised by individual or employer-based purchase of private health insurance coverage, financing through individual and/or employer contributions and ownership of the factors of production by the private sector. The United States is the best example of this category.</p>

Source: Auer, L., Angus, D., Cloutier, J. E., and Comis, J. (1995): Cost-Effectiveness of Canadian Health Care. Research Report. Queen's - University of Ottawa Economic Projects. Ottawa.

doctors are self-employed and reimbursed on a fee-for-service basis (Badgley, 1991; Crichton et al. 1984). In contrast, Britain has a well-established private sub-system of health care services. The private system in Britain is better established than it is in Canada. It is also better integrated into the publicly funded system. Many British doctors supplement their NHS incomes with privately funded medical work that is both encouraged and sanctioned by the government (Ham, 1993; Hargadon and Fry, 1993). During the 90s, the Thatcher government openly supported the private health care sector as a way to take pressure off the bed and service crisis in the public health care system (Klein, 1995). But the existence of private treatment beds also introduced dual standards into the NHS.

As much as both Britain and Canada have a private funding component in their existing health care systems, it is this aspect of a distinct two-tier system in Britain, which is fundamentally different from the Canadian system. The Canadian governments have taken the position that access should be governed by need regardless of their ability to pay and that “two-tier” medicine is categorically unacceptable (Auer et al. 1995, Clarke, 1990). Almost all parties in the Canadian health care system have discouraged private health care in Canada.

In principle Britain espoused the same ideals regarding access to services, but if you could afford to pay to see a consultant privately, care would no longer be determined according to need, only your ability to pay and as a private patient you could now jump the queue for treatment. The private/public split of services in Britain would cause continual conflict between governments, doctors, hospitals and patients (Klein, 1995).

### *Provision of Service*

The benefits covered under the health care insurance plans vary from country to country (OECD, 1987; Murray, 2003). There is total coverage for hospital inpatients, physicians and diagnostic services under the NHS and Medicare. Coverage for other services, such as pharmaceuticals, eyeglasses, appliances, dental care and nursing homes, differ according to such criteria as incomes levels, employment status, region, age and whether there is cost sharing (Swartz, 1993; Auer et al. 1995; Powell, 1997).

## **4.3 Funding Systems**

The health care systems of Britain and Canada are both centrally controlled and publicly funded with most services being financed out of general taxation. The major difference is that Canada’s health care system is characterised by single source financing and hospital funding is based on global budgeting using historical costs rather than pre-determined criteria (Auer et al, 1995; Badgley, 1991). The British Conservative government, under Mrs. Thatcher in 1979, was an enthusiastic supporter of private health care and in the decade following there was an extensive expansion of the private health care sector in Britain (Baggott, 1994). By the 1990s it was shown

that joint working arrangements had substantially increased between the public and private health care sectors. Leadbeater (1990) had reported that about half of the health authorities had used the private acute sector to care for NHS patients; a fifth had been involved in the joint purchasing or leasing arrangement for medical equipment and another fifth had used private-sector screening services. This public-private mix of health care provision in Britain will remain as long as it is encouraged by central government.

The flow of money into the British health care system is much more complex than the resource allocation system in Canada. In Britain, financial allocations based on resident populations are made from the central government, Department of Health via the Regional Health Authorities (RHAs) to the District Health Authorities (DHAs) (Cook, 1998). The DHAs and GP fundholders, in the internal market, act as purchasers of health care for their residents/patients. As purchasers, they are responsible for identifying the health care needs of their respective population and then entering into service contracts with the appropriate provider institutions (Johnson, 1995; Mason and Morgan, 1995; Ham, 1993). The provider market might consist of up to four different types of provider institution competing for contracts with different purchasers (see Figure 4.2).

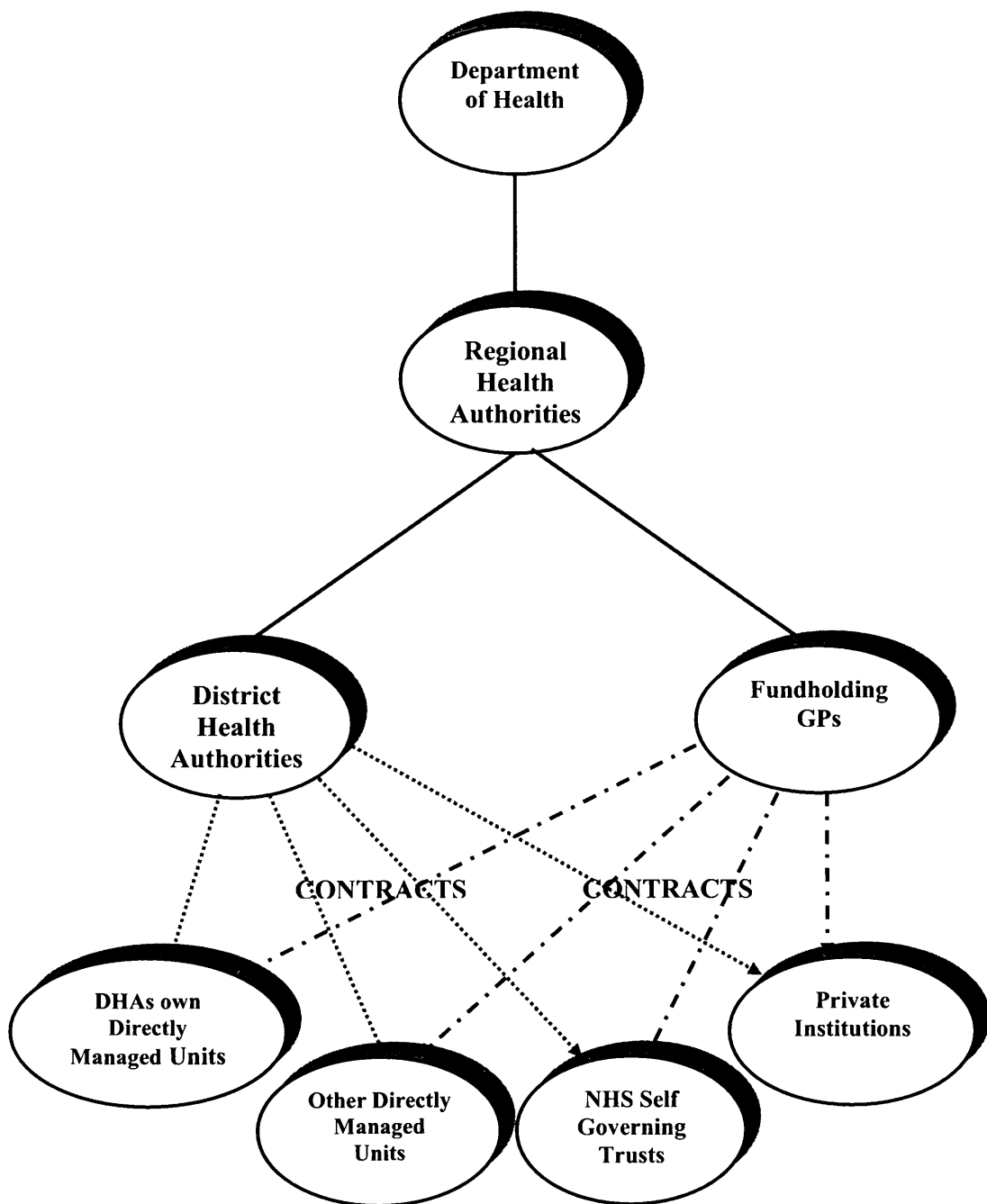
In Canada the financial flow comes from two main sources, the federal government and the provincial government. The main source of financing is from various forms of direct or indirect public taxation. Funding at the federal level is from general tax revenues and increasing deficit financing (borrowing), while provincial funding is based upon a combination of general tax revenues, premiums (fixed monthly charge paid by persons enrolled in the provincial Medicare plan) and user fees (Dickinson, 1988; Badgley, 1991; Narine et al. 1996). Doctors and hospitals charge user fees for certain services not covered by public insurance schemes. The provincial worker's compensation boards, which are funded through employer contributions, cover employees injured at work. Also private insurers cover the costs for services not insured or paid for by government plans, mostly through employer's sponsored plans. Figure 4.3 illustrates how these various forms of financing relate to one another and to the health care system as a whole (National Forum of Health, 1995).

When comparing the financing for both healthcare systems, it is clear that the monopoly of purchasing power by the Canadian government allows the provinces to exercise a great deal of control over the organisation and delivery of hospital services (Dickinson, 1994; Auer et al. 1995). Even though the source of monies in both cases is similar, the British funding process is more fragmented requiring purchasers to budget and allocate limited resources among numerous providers in the field.

The largest health care expenditure in both countries is on hospitals, physicians' services and pharmaceuticals (OECD, 1987). Hospital and physician reimbursement mechanisms vary between Britain and Canada and have been discussed earlier in this chapter. In the British system, payment to hospitals includes the reimbursement of physicians, while in Canada the hospital and physician (usually fee-for-service) payments are separate (Angus, 1987; Ham, 1993). Because hospitals represent the largest health care expenditure, much effort to control costs has targeted this sector. Pharmaceuticals are usually supplied free of charge to patients in institutions and are considered part of the hospital's overall budget (Auer et al. 1995). But the main difference between Britain and Canada is that pharmaceutical coverage is part of the NHS and patients are required to pay a nominal fee for prescriptions. In Canada drugs are not covered under Medicare unless the patient qualifies for social assistance.

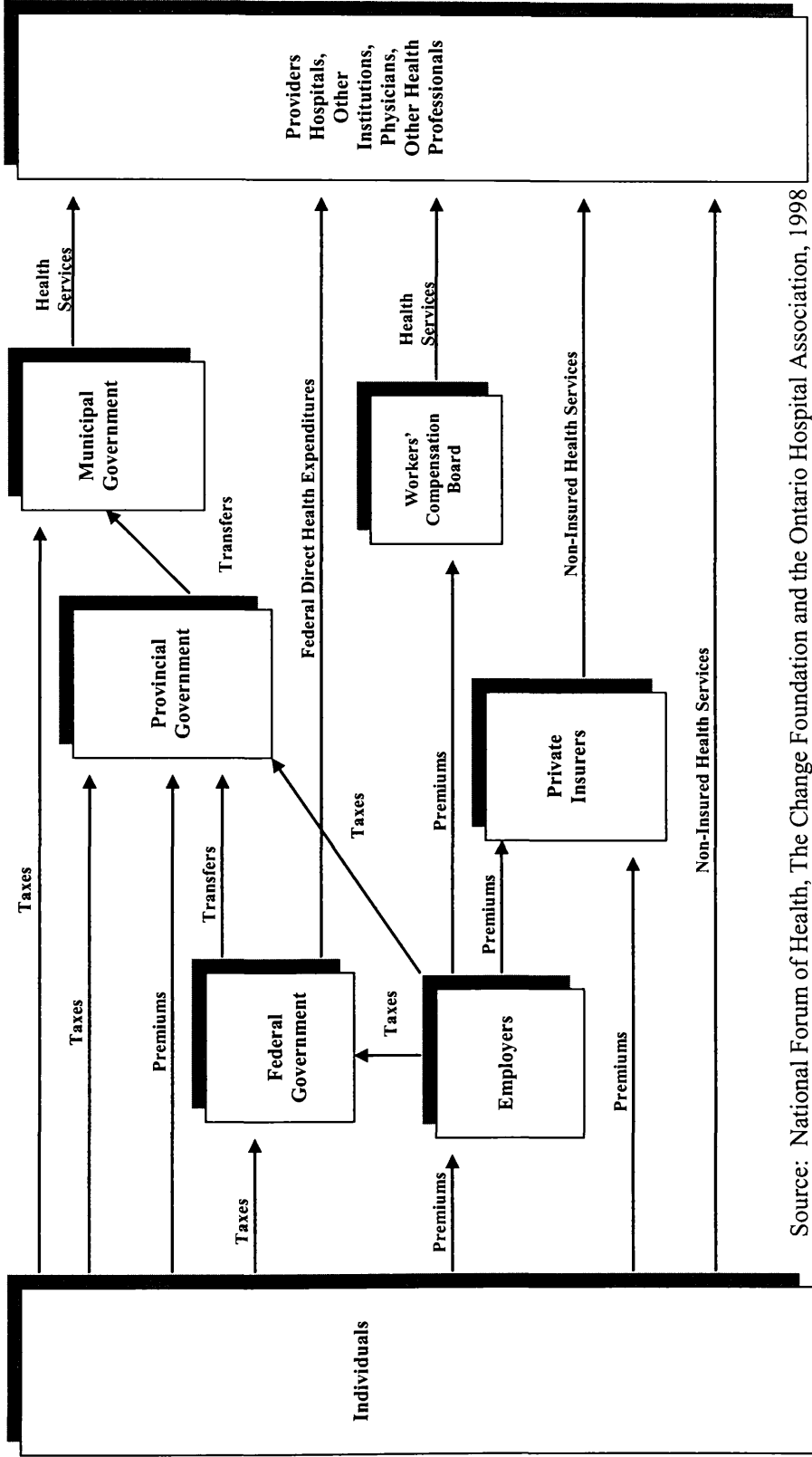


**Figure 4.2: Financial Flows in the British National Health Services**



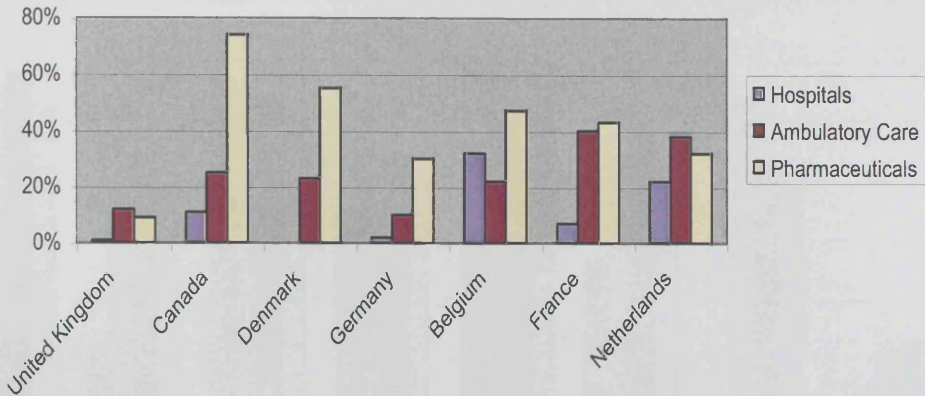
Source: Adapted from Harrison, S., D. J. Hunter and C. Pollitt, *The Dynamics of British Health Policy*. Unwin Hyman, London, 1990. pg. 173

**Figure 4.3: The Funding Structure of the Health Care System in Canada**



Source: National Forum of Health, The Change Foundation and the Ontario Hospital Association, 1998

**Figure 4.4 Patients' Share of Health Care Financing, by Major Sector, Selected OECD Countries**



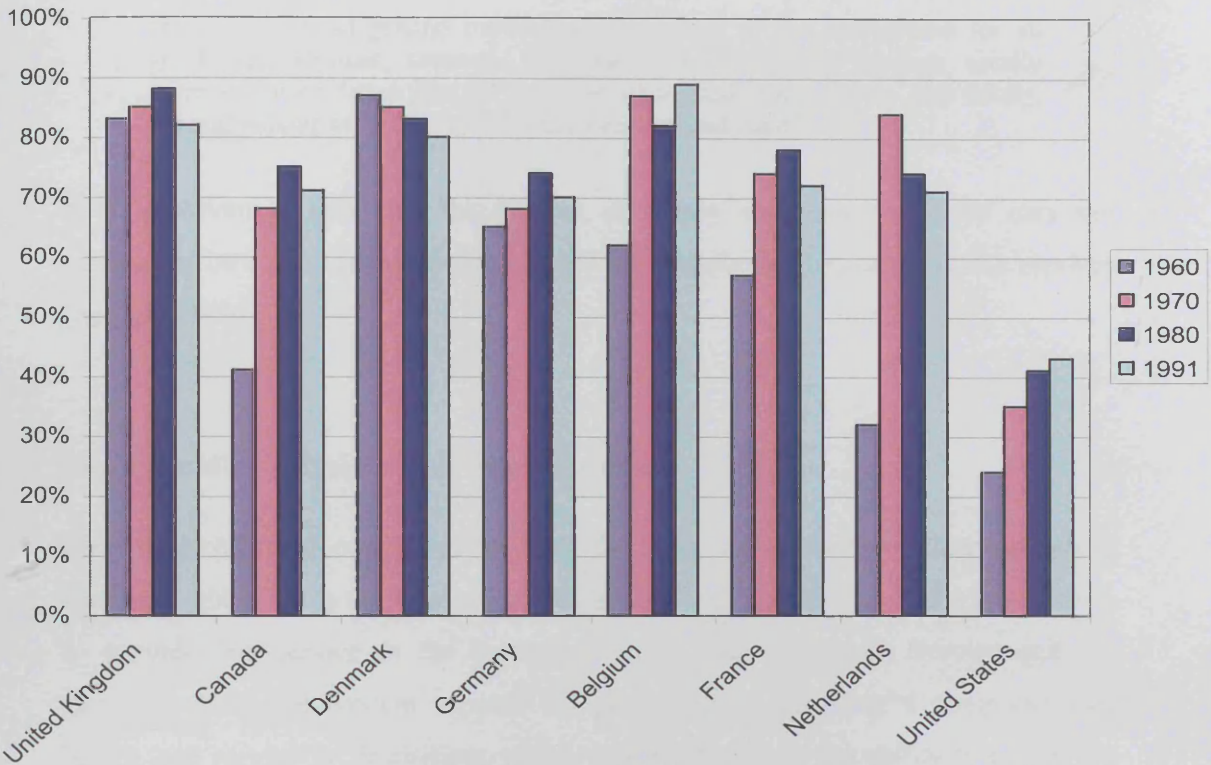
**Source: OECD (1991), *OECD Health Data*, OECD, Paris**

Figure 4.4 above shows the percentage of patients' share of health care financing under the areas of hospitals, ambulatory care and pharmaceuticals of selected OECD countries. The chart clearly shows that patients in Britain are expected to contribute the least to the cost of their health care, while Canadians are expected to cover at least 76 percent of the costs for pharmaceuticals.

This graphic representation shows just how much the NHS government has subsidised health care in Britain and how little the British population pays above the general level of taxation. But these data also paint a context that shows how any change and reform in the system, especially regarding health care costs, is likely to have a larger impact on the British public, who pay less than most other OECD countries.

The OECD has paid much attention to the share of public funding because it appears to have some influence on the consumption of health care services. (Refer to Figure 4.5 below) In Canada, the public share of health care funding increased from about 42 percent in 1960 to 75 percent in 1980. Since then it has decreased to about 73 percent in the 1990s. This was close to the OCED average. In Britain, the public share of health care funding has always been above 80 percent. In 1960 it was around 83 percent and increased to a high of about 88 percent in the 1980s and then fell to an all time low of around 82 percent in the 1990s. Overall the public share of total health

**Figure 4.5 The Public Share of Total Health Expenditures, Selected OECD Countries, 1960-91**



**Source: OCED (1993), OCED Health Systems: Facts and Trends, OCED, Paris**

expenditures has been substantially higher in Britain than in Canada. The trend in both countries was to increase during the 1970s and 1980s and experience a slightly decrease in the 1990s.

### *Healthcare Expenditures*

The spending performance of a health care system is often measured in terms of the country's gross domestic product (GDP). In the early 1990s, healthcare expenditures as a proportion of the GDP ranged between 7 and 9 percent. In Canada the GDP was over 9 percent while in Britain it was under 7 percent (Auer et al. 1995). In the period 1970-80, which was marked by the oil shock of the early 1970s, the growth of health care expenditures still exceeded that of the GDP. In the 1980s, the average growth of health care expenditures relative to GDP decreased. In Britain healthcare expenditures actually grew more slowly than the GDP while the only Beveridge-type

health care system whose expenditures grew far more than its GDP and the OECD average was Canada's, which grew by 21 percent. Auer et al (1995:29) stated that the three main reasons for the increase in health care expenditures were:

“first, widespread general inflation caused prices to rise everywhere for all goods and services; secondly, the prices of health care services usually increased much faster than the prices of other goods and services and thirdly, the real volume of health care services provided had risen”

It is important to note that the amount of money spent on healthcare may not necessarily be a good indicator of the quality and cost-effectiveness of health services (Baggott, 1994).

#### **4.4 Guiding Principles and Belief Systems**

The history of health care legislation in both Britain and Canada are clear that health care is a right and it is the legal responsibility and social obligation of the government to provide this service to the taxpayers. The National Health Service and the Canadian Medicare System support the principles of providing a comprehensive health care service to all citizens, which was not based on the ability to pay at the point of delivery (Fitzgerald and Dufour, 1997; Powell, 1996; Auer et al. 1995; Baggott, 1994). Canadian residents' health coverage is portable to the extent that all services are covered regardless which province you reside or visit and certain services are also covered if you are abroad. The NHS also offers similar coverage.

The major difference between the two systems is the role and pay structure of the medical profession. In the NHS, doctors during the 1990s had complete autonomy in practising medicine and were free to treat private patients while still participating in the NHS scheme (Levitt et al., 1995; Allsop, 1984; Moore, 1995). In Canada, doctors are not allowed to extra bill patients for services already covered under the Medicare scheme (Clarke, 1990). The medical profession is more regulated and controlled by the government in Canada than in Britain. (Northcott, 1994)

## 4.5 System Structure and Government Processes

The British and Canadian health care systems are structured differently yet share many similar functions. The role of the British central government is analogous to the role of the Canadian federal government. The central/federal government does not provide any health services directly but takes responsibility for determining health care policy and allocating resources to the NHS authorities/provinces. In Britain, the central government plays a more active role in setting service priorities, advising the NHS authorities on health care programs and are more directly involved in setting and monitoring service targets and reviewing performance (Allsop, 1995; Ham, 1993). Even though the Canadian federal government plays an important part in setting national policy and providing revenue to support the Medicare system, it is the provincial governments that have the responsibility for the provisions of health care in Canada (O'Neill, 1996).

Basically, health care in Canada is not a national system but a network of 12 quite similar yet distinct provincial healthcare programs. It was only with the Canada Health Act (1984) that the federal government staked out a position whereby it compelled the provinces to operate their health system according to a set of rules reinforced by financial penalties (Crichton et al. 1984; Clarke, 1990). The rationale for federal involvement at this level was the desire to ensure a degree of uniformity in access and provision of health care across the country. This policy set by the federal government at no time attempted to force onto the provinces a "health system"; provinces were left full liberty in the manner in which health care was to be provided, this of course has led to some variation in coverage and structure across the country (O'Neill, 1996). The federal government's leadership role in the development of Canada's health care system came about through its use of spending power. It would be this financial relationship between the federal and provincial governments that would take centre stage and shape health care reforms up to the present.

In view of the above, the best way too make a comparison between Britain and Canada for the purposes of this study would be to compare the NHS in England and the province of Ontario health care system. Many of the roles discussed in relation to

the central government in Britain were similar to the role of provinces in designing, monitoring and reviewing their health care programs.

The British government established Regional Health Authorities across England in 1974; these bodies were accountable to the Secretary of State for Health. Their role was essentially strategic. They were responsible for planning services within their boundaries, within the guidelines set by the Department of Health. The RHAs allocated resources to purchasers of healthcare and would monitor the work and performance of lower-tier authorities such as the Family Health Service Authorities (FHSAs) and the District Health Authorities (DHAs) (Secretary of State for Health, 1993). When the government introduced the 'internal market', it was the RHAs that were responsible for managing the internal market and sorting out any disputes that might arise between the purchasers and providers of health care (Baggott, 1994).

Britain introduced regionalisation before Canada. However, it is interesting to note that all the provinces except Ontario introduced regional structures for health services. Regionalisation as a concept in Canada was open to a broad scope of interpretation and this was reflected in the variety of approaches that have evolved in Canada during the past two decades (Church and Barker, 1998).

As the British government adapted to the introduction of the internal market reforms, additional government agencies were developed at the regional level (regional outposts) and many felt that the RHAs represented an unnecessary tier of bureaucracy and should be abolished (National Health Service Community Act; 1990; Secretary of State for Health, 1993). Ontario had already decentralised planning activities with the gradual introduction of District Health Councils (DHCs) in 1973. These voluntary bodies, with consumer, provider and local government representation, continue to serve as advisory bodies to the Ontario Ministry of Health but had no budgetary authority. The DHC shares many of the same functions as the RHAs in Britain. Its role was mostly strategic and at the local level involved extensive planning and coordination of community services (Mhatre and Deber, 1992). The major difference between the RHAs and the DHCs was the fact that the DHCs did not have the authority to negotiate nor allocate funding to any of the local healthcare providers.

This was a role that would remain firmly within the remit of the provincial government.

Like the RHA in Britain, the DHC in Canada played an active role in overseeing the merger consultation process. Both government agencies found it difficult to mediate the process and even though they tried to remain neutral it was difficult to support the governments change agenda and satisfy the expectations of the local community.

### ***Primary Care Agenda***

Primary care has been regarded as a relatively neglected area, with considerable scope for improvement. The government in both Britain and Canada began to take a more active interest in developing this field believing that primary care had the potential to reduce the demands and financial burden on the hospital service by providing alternative forms of care (Baggott, 1994; Gillett, Hutchinson and Birch, 2001; Shapiro, 1998).

General practitioners (GPs) in both countries have been defined as being self-employed professionals. In Britain, GPs were given a relatively small capitation fee for each patient registered with their practice, while the GPs in Canada were paid on a fee-for-service basis (Secretary of State for Health, 1989a; Navarro, 1991; Clarke, 1990). Both were paid directly from the government. The major difference between the two systems lay in the remuneration of physicians. In Britain, the primary care sector was relatively cheap (in relation to the acute care sector) and predictable for the government to fund and created no perverse incentives for unnecessary extra activity by the doctors (Shapiro, 1998). However in Canada, the remuneration system for physicians was a major cause for concern and was seen to contribute directly to the financial problems in the health care system. Many of the physicians were seen to practice medicine according to their targeted incomes.

During the 1980s both countries began to take a closer look at primary care. The GP was now being regarded as the gatekeeper of the health care system. This role had the potential to impact on costs by regulating access to other forms of care, such as



hospital services (Baggott, 1994; Shapiro, 1998; Gillett et al. 2001). Primary care reform became a priority for both governments.

The British solution was the introduction of the internal market, which introduced GPs to fundholding, while the Canadian government introduced the Health Service Organisation (HSO) program (Ontario Ministry of Health, 1989). As fundholders, the GPs would retain their 'independent contractor' status, but would have stricter terms and conditions of service laid down and funding would now be cash limited (Shapiro, 1998); while under the HSO program, a key goal was to move away from the fee-for-service as a method of payment for physicians and to introduce a capitation funding approach (Gillett et al. 2001; Suschnigg, 2001). This was seen as an alternative to the conventional fee-for-service family practice.

Primary care reform would now play an important role in the development of new models of co-operation and collaboration in health service delivery. These models would promote health maintenance, illness prevention and encourage the use of ambulatory care and community services as alternatives to institutional care. To support this new agenda, the governments (in both Britain and Canada) needed to invest more money into developing the primary care sector. This meant shifting money from the acute sector. It was these fiscal policies on cost containment and the re-investment in primary care that initiated the hospital merger activity in both countries in the 1990s.

#### **4.6 Healthcare Reform: Systems in Crisis**

The cost of health care had risen rapidly during the 1990s and politicians in both countries were concerned about containing these costs. By 1992-93 health care expenditure was consuming 33 percent of the overall provincial budget and 14.9 percent of the British budget (O'Neill, 1996; Levitt et al. 1995; Powell, 1997). The hospital sector of both countries accounted for the largest proportion of the health care budget. Hospital spending in relation to the overall budget had reached 51 percent in the UK and 52 percent in Canada (O'Neill, 1996; Harrison et al. 1990; Powell, 1997) (see Figures 4.6 and 4.7). Therefore it became clear that system reform and the

expansion of primary/community care would be initiated but at the expense of the acute sector (Church and Barker, 1998; Wolfe, 1991; Fitzgerald and Dufour, 1997).

### ***Precipitating Factors***

By the early 1990s, both the British and Canadian governments had reached a crisis point with more and more people believing that the present healthcare system was no longer affordable. Because of funding capitation, the NHS was closing beds, cancelling operations, waiting lists were increasing and there were allegations that the service was under funded (Mohan, 1995; Ham, 1993). At the same time the Canadian government had accumulated a massive federal deficit of \$30 billion by 1991 and was in the process of reducing their transfer payments to the provinces.

This decision by the federal government put considerable stress on the provincial budgets at a time when healthcare costs were rising (Burke and Stevenson, 1993; Ontario Hospital Association, 1998) These economic conditions had now put the Ontario government under extreme financial pressure to find a solution to cost containment.

The governments of both countries believed that many of the problems that plagued the healthcare system were a direct result of poor management practices, inefficiencies in service delivery and organisational problems in the hospitals (Allsop, 1995; Mhatre and Deber, 1992). As a result, both governments acknowledged that action had to be taken to find solutions or new ways of offering the same range of services in a more affordable manner (Lancet Editorial, 1995).

### ***Restructuring Solution***

The British government's solution was to introduce the internal market reforms which signified a shift from the command and control economy to a managed market within the service (Harrison et al. 1990; Harrison, 1991; Loveridge and Starkey, 1992; Mohan, 1995). However, these changes weren't enough to address the government's on-going budget cuts and it's next decision was to impose hospital restructuring sector wide.

Meanwhile the Ontario Ministry of Health in December 1995 announced that the healthcare budget would be slashed by approximately \$1.3 billion and the government's solution came in the form of Bill 26, the Savings and Restructuring Act of 1996. This Restructuring Act gave birth to the Health Services Restructuring Commission whose mandate was to evaluate the Ontario healthcare delivery system and to bring about what ever system changes were required at both the local community level and hospital sector to make the system more efficient and overall accountable (Health Services Restructuring Commission, 1996). The Commission, for the next four years, would be visiting and evaluating every healthcare community across the province and conducting reviews based on studies carried out by the District Health Councils. This was the beginning of hospital restructuring, mergers, closures, conversion of hospitals to community health centres and the building of a new integrated healthcare system in Ontario (Lancet Editorial, 1995).

Both of the government's in each case were unable to sustain and continue to finance their present healthcare systems. Therefore in response to this crisis, each decided to bring about legislative reform which in the British case resulted in an unprecedented pace of change and in the Canadian case the reforms fundamentally gave the government unparalleled power to instigate any changes they wished to make. In each case the same problems were identified and both governments in order to contain costs decided on a restructuring regime of hospital mergers and closures during the 1990s.

#### **4.7 Conclusion**

It is a unique aspect of this study that each case of public sector hospital restructuring, is based in a different country yet the contexts of both cases are very similar. The Organisation for Economic Co-operation and Development (1991) has classified both these healthcare systems as Beveridge models. The Beveridge classification is based upon a distinctive type of delivery system and the funding structure. It is fair to say that both the British National Health Service and the Canadian Medicare System espouse and support the same values and beliefs about the kind of health service that is available to all residents in each country. Health care is free at point of delivery, and it is the responsibility of the government to provide a comprehensive service to all residents. The funding systems are both government controlled, publicly funded and

financed out of general taxation. A key point to note is that, translated into the terms of Fligstein's institutionalism, the state is a very powerful actor, the most powerful actor, in both cases. Indeed, by virtue of its power to define the rules and boundaries in the health care field, the state can alter the environment more profoundly and systematically than any other organisation (Fligstein, 1990)

The structure of the healthcare system and the government bodies at the regional and provincial level in each country are different. . The central/federal governments, in England and Ontario respectively, have decentralised planning and the allocation of resources to the next level of government. Ontario is not regionalised like the other provinces and as a result the allocation of resources has remained firmly under the control of the provincial government. Whereas in Britain, the RHAs have been delegated more fiscal responsibilities at the local level. Healthcare planning is a role that has been delegated to the District Health Councils in Ontario but as an organisation staffed mostly by volunteers there is no real power attached or available to this local level organisation.

One strategic planning priority shared by both countries was the move toward developing, improving and expanding primary care services. This new role for primary care was seen partly as the panacea for reducing the financial burden of the hospital sector.

The healthcare crisis of the 1990s affected both countries and the precipitating events, the emerging problems and the restructuring solutions were remarkably similar. In both places it was decided that the steeply rising costs of healthcare had to be contained. The governments in both England and Ontario decided to take direct action. The governments' solution was to introduce legislative reform policies that would have a major impact on health delivery systems. These reforms represented a major ideological shift which had an obvious impact on the health care system. They also had an effect in shaping what we shall conceptualise at a later stage as the organisational field of health care in the two counties. The internal market reforms in England changed the roles and relationships between government and other organisations in the healthcare field and the creation of the Health Services Restructuring Commission in Ontario are examples of the government's concern

exercising unprecedented power to make system wide changes. Both reform agendas resulted in large scale government led change and extensive hospital closures and mergers.

## CHAPTER 5

### THE ENGLISH HOSPITAL CASE STUDY: THE MERGER OF ACUTE HOSPITALS IN NEWCASTLE

#### 5.1 Introduction

This case study research seeks to provide an understanding of how changes occurred in public sector acute hospitals in Newcastle upon Tyne in the early 1990s, in the wake of the government's introduction of radical reforms of the NHS. A case narrative methodology was chosen for the reasons stated in the Methodology (see Chapter 3). In analysing the processes of change that were observed, the study draws on Greenwood and Hinings' concepts of archetypes and tracks of change together with Neil Fligstein's synthesis of conceptual insights into organisational fields, power and social skill.

The concept of archetype is used to define the nature and scale of change in the hospitals under review, i.e. whether change is consistent or not with a move between one coherent pattern of organisation and a new one, and whether change can best be described as incremental or quantum movement. Organisational transformation may be analysed not only at the level of a single hospital organisation, but also at the level of the organisational field (Ferlie, 1999): in this case the Newcastle health care sector. Greenwood and Hinings (1996) recognise that it is at the organisational field level where we can both identify the normative contextual pressures that maintain stability and locate the dynamics of change. However, in considering both precipitating and enabling factors of change, archetype theory's main focus is on interactions between actors within an organisation. Given the interdependency and interaction of the organisations and actors in the field under study, Fligstein's ideas of fields, power and social skill are integrated into the researcher's theoretical framework for analysing the dynamics of change because his ideas focus on interaction within the field and not just within an organisation.

It will be argued that external forces, located in the organisational field, precipitated

change in the hospitals under study. The reforms passed into law by the NHS and Community Care Act 1990 were designed radically to challenge the NHS and pressure both the administrative structure and the hospitals to move from a bureaucratic hierarchy, comprising district and regional health authorities and ultimately the Secretary of State for Health, to an internal market in which ‘purchasers’ (health authorities and some family doctors) were given budgets to buy health care from ‘providers’ (acute hospitals, organisations providing care for the mentally ill, people with learning disabilities and the elderly, and ambulance services). To become a provider in the internal market, health organisations needed to become NHS Trusts: independent organisations with their own managements, competing with each other in a health quasi market. Hospitals would need to find and adopt a new pattern of organisation that was suitable for the new context, and they would strive to do this within the new form of trust hospitals. The 1990 Act, in fact, created both a new market context and the general pattern for a new structural form of hospital. However, there was no guarantee that any particular hospital would actually achieve a new coherent pattern of organisation and it will be shown that, as to what actually emerged, much depended on the pattern of interactions at the local level that followed these nation-wide policy changes. In this instance, as will be shown, a change to a new coherent archetype does not, in the end, transpire. The reasons for this have more to do with the way the reform process was implemented at the local field level than with the imposed nature of the reforms as such, as similar policy reforms were imposed in both England and Ontario, with very different results.

The study begins in 1990, when the first applications were made by Newcastle hospitals for trust status. The end marker for the case is June 1994, when, only two months into the merger, the decision was made by the newly merged hospital to look to the PFI scheme for funding.

## **5.2 Introducing the Actors: the Organisational Field**

The concept of organisational field is important to understanding what happened in the cases. Change was politically induced, and implemented by government agencies through the administrative structure embodied in the field. The field in which the

three hospitals operated consisted of numerous interdependent actors. The government, through the agency of the RHA and the DHA was (both before and after the 1990 reforms) ultimately responsible for funding all medically necessary hospital services. The University of Newcastle upon Tyne Medical School (“the University”) was involved in medical teaching activities with all three hospitals. Doctors and other health professionals interacted informally among themselves and with hospital administrators, the University, and social service agencies in order to provide appropriate services for patients, including specialised treatment. The local Community Health Council (“CRC”) interacted with the hospitals and other NHS health organisations, government agencies and the public in its role as an independent consumer council set up by the government to monitor and review the NHS and to recommend improvements. These key actors in the field would interact with each other continuously (sometimes in antagonistic ways) and use their varying degrees of power to pursue their own interests (Fligstein, 1990). The configuration of hospitals in Newcastle at the outset of the case is shown in Figure 5.1.

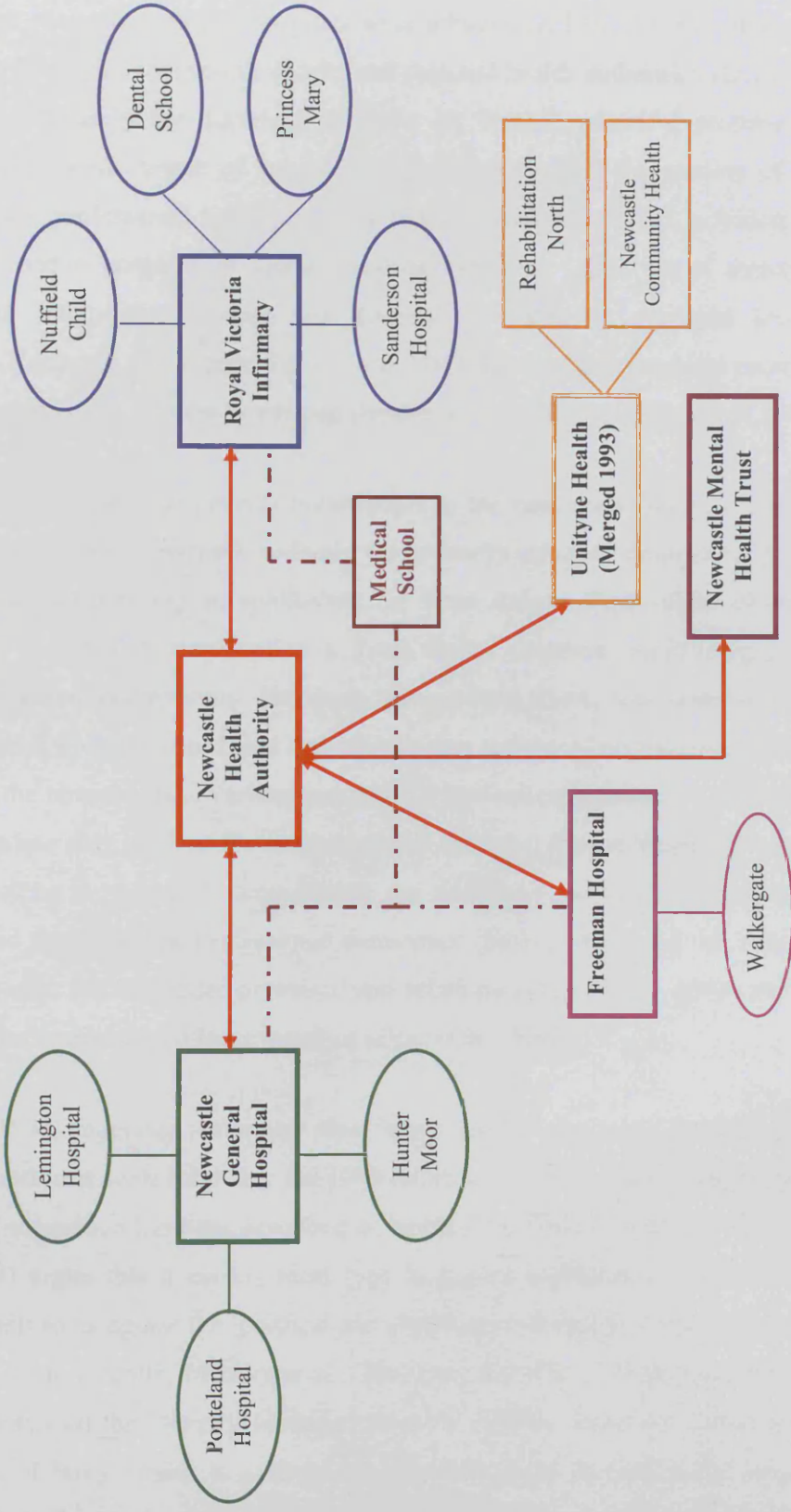
In statements made by the various individuals interviewed during this research and also in the case documents obtained, the term ‘stakeholder’ is used simply to denote a person or organisation (individual actor), or a group of persons or organisations (group or collective actor), having an active interest in the workings of the health sector. It is not intended to be interpreted in a theoretical analytical manner, as in stakeholder analysis (e.g., Freeman, 1984; Jones and Wicks, 1999). This is also the researcher’s personal experience, having worked for many years in the health care sector in both the UK and Ontario. Accordingly, when used in this Chapter and the following Chapters, the term ‘stakeholder’ simply means ‘actor’ and carries no connotation of stakeholder analysis, which is not used in this research. However, where the context permits, government agencies are referred to by their specific names (for example, the RHA).

### **5.3 Initial Archetypes**

Before the introduction of the 1990 reforms, the interpretive scheme underpinning the set of structures and systems in UK public sector hospitals consisted of three key



Figure 5.1: Newcastle Hospital Configuration Prior to the Acute Services Review, 1993-1994



Source: Author

elements. First that treatment should be given, free at the point of delivery, in a stable environment. Second, although hospitals were administered by the state through a bureaucratic hierarchy comprising district and regional health authorities (DHAs and RHAs) and ultimately the Secretary of State for Health, powerful professionals practised with a high degree of autonomy, reinforced through the process of peer review and the professional management of clinical practices. Third, a widespread anticipation within hospitals of annual funding increases. This set of structures, systems and interpretive scheme was labelled the “directly managed hospital archetype” (Kitchener and Whipp, 1997). This old NHS template has been presented as highly homogenous, evident across populations of organisations (Kitchener, 1998).

At the outset of the change process investigated in the case under study, two of the three acute hospitals in Newcastle had only very recently achieved Trust status and the third was actively pursuing an application for Trust status. Trust status of course entailed the compulsory introduction a Trust Board structure conforming to the relevant legislative requirements. However, as suggested above, that alone would not guarantee that a hospital would find and adopt a new pattern of organisation that was suitable for the new context. Various factors both internal and external to the hospital would come into play, such as the continuing role of higher tiers in shaping the quasi-market (resulting in ‘managed’ competition), the response of medical professionals to the perceived threat to their professional dominance (Ferlie, 1999) and the effects of the quasi-market on local inter-organisational relations (Mays et al., 2000) and any other empirically discovered local variables (Dent et al., 2004).

Kitchener (1998) suggested that a new ideal ‘quasi market’ archetype emerged over a relatively short time scale following the 1990 reforms. However, this is questionable. Kitchener’s suggestion has been described as ‘bullish’ by Ferlie (1999:12). Exworthy et al. (1999) argue that a market ideal type is a poor representation of the NHS because it fails to recognise the ‘political and organisational complexities of the NHS’ (1999:17). More recently, Mueller et al. (2003) suggest that a ‘Trust Hospital (TH) archetype’ replaced the Directly Managed Hospital (DMH) archetype following the introduction of NHS Trusts. It is based on principles such as managerial authority (instead of professional autonomy); self-sufficiency through financial discipline

(instead of lobbying political bodies); internal (rather than external) management of the asset base; 'realistic' contract prices (rather than cross subsidy between services); and staff recruitment requiring business (rather than professional) justification (Kitchener 1998, 1999; Kitchener and Whipp, 1997).

Since, at the outset of the case, two of the Newcastle hospitals had only just become trusts and the third was still in the process of applying for Trust status, the initial archetype-in-use in the present case is best identified as the Directly Managed Hospital as the hospitals had not yet, at that stage, actually undergone any transformatory 'change' to a new template but were, rather, in a nascent state of 'changing' (Weick and Quinn, 1999:382). The direction of such changing was not predetermined (Loughlin, 1991) but subject to empirical investigation in the case.

As in the Ontario case study, the hospital merger was part of a restructuring of local public sector health care services the aim of which was to produce an integrated local health care system that would accommodate changing trends in health care requirements and operate effectively within given financial constraints. In each case the hospitals would have a degree of managerial and financial autonomy (in the English case this assumed Trust status). Within this overall context, there would clearly be very considerable scope, in each case, for differing conceptions among the various groups of actors as to what the hospitals should be doing, how they should be doing it and how they should be judged (Greenwood and Hinings, 1988).

#### **5.4 Institutional Upheaval: Early Tracks of Change**

In 1990-91 the three acute hospitals in Newcastle embarked on similar tracks of change when they each applied for Trust status. Thus, there is evidence of a reformative commitment across all three acute hospitals in Newcastle which would interact with the market and institutional reforms of 1990 to create pressure for radical change in the local hospital field (Greenwood and Hinings, 1996:1037). The Freeman and NGH applied in 1990; the Freeman was successful but the NGH was not. The RVI applied in 1991 and was successful, becoming a Trust on 1 April 1992. Thus the

hospitals' tracks of change took different directions with the outcome of their Trust applications. NGH would subsequently go on to prepare a second application in April 1993 in the fourth wave, but as we shall see the setback suffered by NGH at this stage altered the power balance in the field.

In 1992 all three hospitals were not only facing the general market pressures of the 1990 reforms but were also struggling with local financial constraints. A capitation shift in funding resulting in a loss of more than £12m would severely impact on the purchasing power of the DHA, and further substantial cuts in its funding were expected. The three-hospital configuration was becoming increasingly unaffordable [177]. There would need to be a new, affordable institutional arrangement for the future provision of acute hospital services in Newcastle.

## **5.5 Strategic Alliances**

There was evidence that in striving for a new, stable institutional configuration of acute hospitals in Newcastle, the RHA favoured the Trust hospitals and employed a combination of two of the methods in which stable institutions can be built: by enforcing order and privileging its most favoured groups and by forming a political coalition with those groups to bargain an outcome that would provide rules for those groups (Fligstein, 2001: 108).

It is relevant to the analysis that at this time the RVI and the University were heavily committed to each other financially. The RHA was in the process of financing the construction of a new medical block for the University on the RVI site at a cost of £35m. The University managed many government-funded research programmes. The Dental School was also located on the RVI site and had recently received substantial government funding for its brand new state-of-the-art laboratories.

By September 1992 private discussions were underway between the RHA, the RVI and the Freeman about a possible move to a two-hospital configuration in the city. The RHA asked the CEOs of the RVI and the Freeman Hospital to prepare a briefing paper outlining their views on the restructuring of hospital services in Newcastle [135c, 177]. Minutes of the discussions record:

“Purchasers have asked the RVI and Freeman Chief Executives for a preview of the proposals; early indications are of a favourable response”. [133]

NGH was not aware of these discussions. The political alliance underpinning these discussions altered further the power balance in the hospital field and signalled the beginning of the local reorganisation of acute hospital services in Newcastle. It also marks a further movement along the Trust hospitals’ tracks of change as they sought to define their own roles in the now changing organisation of health care in Newcastle.

The briefing paper prepared by the CEOs of the RVI and Freeman (known as the ‘Larry’ document - so called by combining parts of the names of its authors) was submitted to the RHA in October 1992. It recommended that the RVI should be the focus for medical education underpinned by a full range of general acute services and complemented by a number of specialist interests. The Freeman should be established as a regional tertiary care centre concentrating on highly specialised services complemented by a core of general acute services, while NGH should become a community based hospital with an emphasis on day care and primary care support complemented by specialist outreach and diagnostic facilities which would remain on site. This proposed reconfiguration was based on a two-hospital solution for the future service provision of general medicine and general surgery, and only just stopped short of closing the NGH site altogether. NGH’s role would be totally re-defined, while the RVI and Freeman would maintain their present services and inherit the NGH acute services [177].

In November 1992 NGH notified the RHA of its intention to apply for Trust status, whereupon the RHA promptly sent a fax to the RVI to informing the RVI of NGH’s intention. If NGH were to secure Trust status it would be extremely difficult to implement the proposed two-hospital model. The next day, the ‘Larry’ document was leaked to the press [3c, 3d, 3e]. The RVI and the Freeman issued a press release stating that they regretted the leaking of this draft report, which they claimed was prepared primarily to stimulate debate about the future of health care services in Newcastle [138].

## 5.6 Conflict and Political Dynamics

The Newcastle Evening Chronicle [3c, 3d] reported the information leak with headlines that read:

“Secret Report Reveals Shock Take-over Plan by RVI and Freeman” “General Under Threat: Respected Teaching Hospital - 150 years of Caring”.

The newspaper’s main criticism was that the future of the region’s biggest hospital should not be decided by its two rival Trusts. NGH consultants were quoted in the newspaper, one stating:

“it is ridiculous to asset strip NGH to pay for more expensive medicine at the Freeman and the RVI. These two hospitals should bear the brunt of cuts, not NGH, which provides the right clinical mix with the least cost.” (Wilsdon, J. B., 1992)

The CEO of NGH in an interview with the leading journal for the health sector accused the Trusts of seeking to:

‘take over’ local services, deplete provision in Newcastle’s underprivileged West End and fix the market.” (Health Services Journal, December 1992)

The Member of Parliament for Newcastle Central highlighted how the RHA and DHA stood back and allowed the power-crazy Trusts to fight it out (see press release *‘Newcastle Hospitals Civil War Breaks Out’* - Evening Chronicle, 26<sup>th</sup> November 1992). This accusation goes even further in a letter to the RHA from the same MP, which states:

“the two Trusts (RVI and the Freeman) have made their own plans. Essentially to strip NGH of all its acute treatment functions. But their proposals go much further. Nor do they disguise their object, which is to transfer the capitation gains of those areas by organisational force, and not market force, to their own operations. This is a most serious and well planned attempt to construct a cartel.” [138]

Similarly, one senior Trust executive said when interviewed for this study:

“It was quite simple: there were too many hospitals in Newcastle and not enough money. So the two biggest got together and decided to basically crush and eliminate the smallest.”

A senior NGH executive interviewed said:

“We had no idea about the depth of the conspiracy unfolding behind closed doors”.

These statements with references to “take over”, “asset strip”, “fix the market” “civil war”, “organisational force”, “crush and eliminate” and “conspiracy” reflect the conflict that characterised the change process that was now evolving. The statements also highlight the politics involved in the process. The RVI and Freeman are portrayed as the sole conspirators and the RHA and DHA as passive bystanders, indicating that attention had been successfully diverted away from the behind-the-scenes manoeuvring of the RHA. The Freeman is perceived as one of the two “biggest” hospitals even though it was well known to be the smallest [118]; this reflects an assessment based on the perceived political power of the Freeman rather than its size. As one NGH consultant observed when interviewed:

“It’s all about politics and turf protection. Everyone knew the General was larger than the Freeman, had more in-patient and outpatient services and regional recognition of its speciality services. Plus its overheads and unit costs were less than at the Freeman and the RVI.”

## **5.7 Social Skill**

It is clear from the data that the RHA had already decided that NGH should no longer continue as an acute hospital and was adopting a highly political approach to bringing about this change. As a key actor, the RHA had many constituencies to balance off and was aware of the need to produce arrangements to induce co-operation with allies and opponents alike (Fligstein, 2001:111). Outright closure of NGH by the RHA (through the DHA) would have been politically unacceptable, and simply leaving the fate of NGH to be determined by the internal market would still have left the government and its agencies open to political flack. As Enthoven observed:

“The internal market neither had nor created any “political space” within which markets could work to reorganise services. The public continued to hold government responsible for any changes in the configuration of hospital services, so government’s interest in the details of hospital services remained high. It has always been....important for the NHS to avoid doing anything that might upset voters, or even to talk about doing any such thing. As Charles Shultze explains it, the government cannot be seen as inflicting direct harm on anybody, such as by cutting back on the services of a local hospital. So changes that involve curtailing some services to transfer resources to more productive uses happen only with considerable difficulty. Every proposed change is immediately a political issue. Private market forces, on the other

hand, are impersonal and do not provide a visible political target for the opponents of change.” (Enthoven, 2000:106-107)

The data show that, instead, the RHA chose to use its power at this stage of the change process in a more strategic way. Here, in the behind-the-scenes alliance with the Trust hospitals leading to the covert preparation and deliberate leak of the “Larry” document, we see the use by the RHA of a ploy used by strategic actors to get others to co-operate without appearing Machiavellian: getting others to believe that others are in control; an example of “social skill” (Fligstein, 2001:115).

Demonstrating a continuous reformative value commitment, NGH continued nevertheless with its plan to apply for Trust status and responded to the Larry document in a detailed report proposing that some peripheral hospitals should close and that the three acute providers should be able to continue and build upon their existing strengths at a relatively low capital cost [4]. It appears that the RHA and DHA ignored this report. NGH is thus seen as proceeding on a track of change that is already beset by conflict and incoherence.

We have seen how the RHA set the dynamics of field-level change in motion. In the next section we examine the way in which the government through the RHA used its position as the most powerful actor in the field to control the direction of that change.

## **5.8 Setting the Agenda: The Acute Services Review**

The RHA had decided by this stage that the present system of health care services could not continue in Newcastle, but acknowledged that it would be impossible to achieve consensus among the key stakeholders [141]. The next step taken by the RHA would have a fundamental impact on the restructuring of the hospital field in Newcastle and in particular on the tracks of change within each of the three acute hospitals.

In January 1993 the RHA launched a review headed by the DHA and (although formally called the ‘Newcastle Strategic Review’) commonly referred to as the ‘Acute Services Review’ or “ASR”. The membership of the ASR Group reflected the purchaser-provider split introduced by the 1990 reforms: seven DHAs, the RHA, the



three acute hospitals, Newcastle Mental Health Trust, UnityNE Health Trust, and the University [141]. NHS Estates and the York Health Economics Consortium provided research and consultancy services [107, 117].

The Review would consist of a three-stage process. First, the writing of a Joint Purchasing Strategy to apply across the DHAs. Second, discussion and identification of possible configuration options for the acute hospitals [182]. The third stage would prove to be the most critical part of the Review. This would involve a participative workshop for all of the key stakeholders to assess hospital service options against the criteria identified in the Joint Purchasing Strategy and to reach a clear consensual view of a preferred strategic option [96]. There would also be structured discussions with all the GP practices in Newcastle, the hospital consultants, other Tyneside acute providers, the University and the Newcastle CHC.

In the four months leading up to the workshop the seven DHAs developed a Joint Purchasing Strategy that provided criteria by which the workshop group would be able to judge the options put forward for service re-configuration [102, 182]. The UK government's introduction of competitive commissioning meant that the Newcastle DHA would no longer be the main purchaser of health care services in Newcastle and that purchasers in the surrounding districts would begin to have more influence on the services provided by acute Trusts [96]. Therefore the emphasis on spending would now be more about core services than about estate maintenance for the acute provider, so that acute providers might have to consider locating acute services onto an estate which would require less maintenance and be sustainable on a smaller annual income. This change would play into the hands of the RVI and the Freeman. The NGH site would require extensive re-development and had a growing backlog of maintenance problems, while the RVI, already in receipt of a large amount of government investment capital, was undergoing extensive re-development and the much newer Freeman was located on a large plot of land which had potential for future expansion [107].

In launching the Acute Services Review and formulating the Joint Purchasing Strategy as the basis for discussion, the government through its RHA and DHAs is seen to be

using another tactic used by skilled actors: agenda setting. According to Fligstein (2001:114):

“Agenda setting is usually attained by behind the scene action to convince multiple actors and groups that a particular agenda is in their interests. When the groups meet, the agenda is set, the terms of discussion are set, and the identity and interests of actors are framed. This requires actors to come to understand their interests within certain bounds and closes off some courses of action”

## **5.9 Stakeholders’ Values and Interests Articulated**

Several key stakeholder groups were asked to submit reports to the Review Group (the stakeholder groups involved in the Review process are shown in Figure 5.2). Each group was asked to provide a list of criteria it considered would be essential in order to develop an efficient service, meet the clinical needs and provide quality patient care to the population of Newcastle. This would prompt the stakeholders to articulate elements of interpretive schemes as purposive values and interests that could potentially lie behind the strategic implementation of a new structural framework for local hospital services. In fact, as illustrated by the submissions outlined below, most of the stakeholder groups raised concerns about the negative impact they believed certain options would have upon the Newcastle area [75, 78, 80, 82, 83, 84, 86, 87, 115].

### ***General Practitioners***

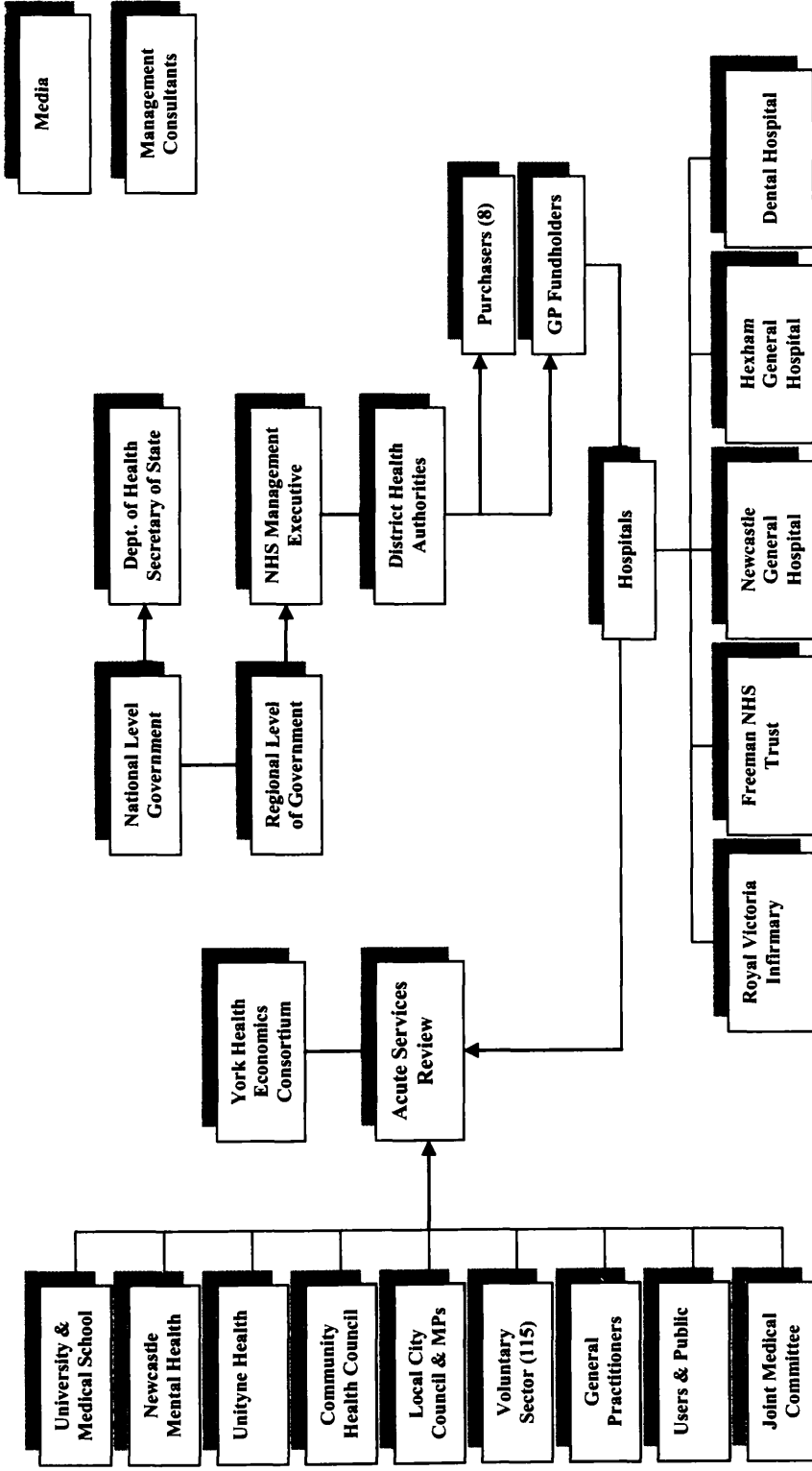
The GP group was concerned about bed availability, improved communication between the hospitals and primary care, reduction in waiting times for consultants appointments and the need for additional resources prior to any service changes in the acute sector [111]. The following views were expressed by GP fundholding practice managers interviewed:

“It’s all very well to put primary care development as a priority but it’s still important to have the support and access to acute care.”

“If the government expects primary care to offer more services it had better be prepared to invest more money and recruit more health professionals”

“NGH was an integral part of local life. It was easily accessible and receptive to community needs. Closure was a disaster for the people of the West End.”

**Figure 5.2: Stakeholders Involved in the Newcastle Acute Services Review**



### ***Medical Consultants***

The Consultant group took the view that potential changes in clinical practice would put pressure on relevant specialities and this would influence the need for different hospital facilities such as day case facilities. It was not the intention of their report to recommend service re-configurations but the consultants believed that once an option was adopted, the interrelationship between specialities was essential. A key concern was summarised by one of the key medical staff as follows:

“Service reconfiguration is just the tip of the iceberg. Integration success will depend upon cross site consultant collaboration and without this, the whole plan will collapse at the expense of patient care” [112]

### ***The University Medical School***

The University was concerned that any plan to reconfigure hospital services must take into account the needs of postgraduate medical education [88, 90]. A senior medical academic interviewed observed:

“Medical education is the backbone of the system and patient care. If anyone should have a voice at the table, it’s us.”

Medical postgraduate training was regulated by formal educational bodies, subject to NHS regulations and practice guidelines and was required to comply with national agreements. Locating services on split sites could create problems for medical training and supervision and limit the breadth of clinical experience for the medical student [114]. It was fairly clear that the University would favour the two-hospital model of service delivery in Newcastle and not the slimmed down version of three acute units [91].

### ***The Community Health Council and Voluntary Sectors***

The CHC organised 26 user and resident focus groups across Newcastle, ensuring that they represented different geographic localities and a range of ages, gender and cultural backgrounds [180]. The voluntary sector sent questionnaires to 115 groups, representing service providers, community development projects and users [181].

Location was a major concern for residents in the West End of the city where there was a clear allegiance to NGH:

“NGH was an important part of the West End. This hospital supports a very large ethnic and poor population in the city. Many people depend upon the accessibility of these local hospital services, especially its A & E. To close this hospital will pose serious problems for many of the local residents.”  
(Senior Hospital Executive)

A common complaint was that the public had not been given adequate information about the RHA’s plans to transfer hospital based services to primary care settings and therefore many respondents were not convinced that the proposed changes would improve patient care.

### *The City Council*

The City Council argued that NGH’s closure would have potentially dramatic economic effects, creating immediate and long-term unemployment amongst those directly employed and those who supplied goods and services to the site. The city’s transport infrastructure would be substantially affected by closure or severe cuts in services offered at the NGH site and the viability of certain public transportation routes would be in jeopardy [110].

In addition to the economic factors, the provision of health care in the West End would deteriorate dramatically, further increasing the perception that this part of the city was under-resourced and neglected. NGH was a vital cog in the community care programme in the West End, which was the area of greatest deprivation and had the largest proportion of people from ethnic minorities.

The Council considered that NGH had been severely hampered by lack of Trust status, making it difficult to compete with the other two acute providers. It also was outraged by the diminishing commitment to public accountability in all the proposals that were being debated around the re-configurations of hospital services in Newcastle [110].

The views of the City Council and the CHC were the most independent and objective of all the submissions made to the Acute Services Review Group. It is notable that even though common concerns (articulated purposive values and interests) were

emerging across some stakeholder groups, there was no political alliance formed these groups to challenge the leaked ‘Larry’ proposals, and no public meetings were called to debate the matter, even though the proposals were now in the public domain due to media coverage.

### **5.10 The Seaburn Workshop – A Key Turning Point**

The third stage of the ASR would prove to be an “institution building moment” in which key stakeholders and in particular the three hospitals, now with varying power depending on their Trust status and political alliances, would confront one another in the struggle over scarce resources (Fligstein, 2001). The Review Group’s workshop was held over two days in April 1993 at Seaburn, near Sunderland. The groups of key stakeholders represented in the Group would make strategic decisions at this workshop that would change the face of health care in Newcastle. The workshop was chaired by the CEO of the Newcastle DHA [102]. The stated aims of this workshop were: (i) consider and discuss the reports submitted by the various community stakeholders and special working groups, the NHS Estates and York Health Economics Consortium, (ii) identify the key issues and propose solutions at the strategic level, rather than the operational level, and (iii) use this forum as an opportunity for practical debate rather than approving or rejecting predetermined proposals [107]. Figure 5.3 shows the six options discussed at the workshop.

Post-workshop feasibility testing would involve public consultation on the option chosen by the workshop participants. A detailed analysis would be conducted to determine whether the option could be achieved within the limits determined at the workshop and whether the identified option would be capable of delivering projected benefits in terms of service quality and capital/revenue release [102].

The RHA again demonstrated social skill in presenting itself as neutral in the ASR – it did not submit any proposals of its own and merely co-ordinated the Review process – and appeared more as selling the group collective identity and appealing to the other members to reach a consensus. In short, it engaged in “brokering more than blustering” (Fligstein, 2001:114). Yet, the underlying reality was that NGH was being coerced into submission. NGH was heavily outnumbered by other members of the

Review Group whose interests conflicted with the continued existence of NGH as an acute hospital. Seven members of the Group were government organisations (purchasers) that were allies of the RHA. The two other acute care providers, the RVI and Freeman, were keen to acquire NGH's financial surplus of almost £3m and its high profile, well-developed clinical programmes [151].

Several of the stakeholders who attended this workshop were interviewed. All commented on the intensity of the group dynamics, the politicking between key groups and the animosity directed at NGH by the RVI and Freeman; several reported that as the workshop proceeded it became apparent that there had already been some deal making behind closed doors. NGH was the most vulnerable stakeholder at the workshop because it had not achieved Trust status and was still being directly managed by the DHA [127, 65]. NGH, and other stakeholders who supported NGH, were already feeling undermined by the political manoeuvring of the RVI and the Freeman and the leak of the Larry document.

“The RVI was out to conquer and the Freeman was its partner in crime.”  
(Community Stakeholder)

“The Newcastle General was always seen as the poor relation. Let's face it, the RVI was running the show and calling all the shots. The Health Authority was quite happy to take a back seat.” (Senior Hospital Executive)

“The RVI was often referred to as the Kremlin and don't think for one minute that the leaking of the Larry document was any accident - it was all politically choreographed down to the last step.” (Senior Hospital Clinician)

**Figure 5.3: Acute Services Review - Options Discussed at Seaburn Workshop**

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**Options Discussed at Seaburn Workshop**

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**Option 1**

Retain the existing organisation and services in all three acute hospitals with the current number of beds.

**Option 2**

Reorganise all acute hospital services onto the Freeman site; close the RVI and NGH.

**Option 3**

Reorganise all acute hospital services onto two hospital sites, Freeman and NGH; close RVI.

**Option 4**

Reorganise all acute hospital services onto two hospital sites, Freeman and RVI; close NGH.

**Option 5**

Retain all three acute hospitals, but smaller.

**Option 6**

Reorganise acute hospital services onto two hospital sites, Freeman and RVI, and establish new style services at NGH linked closely with strengthened primary health care.

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Source: Newcastle Health Authority, Newcastle Health - A Concept for the Future: Update, July 1993.



NGH was brutally attacked at the workshop and the aggressive tactics used by the RVI led to conflict and the polarisation of group loyalties. Several interviewees reported that the CEO of NGH had been literally reduced to tears. Recent studies indicate that governments have shown a tendency to seek to impose change using a variety of coercive mechanisms, such as, for example, central performance targets, league tables and even threats of intervention in the case of “failing services” (Kirkpatrick and Ackroyd, 2003:10). In this workshop we see another form of coercion in the combination of overwhelming political alliances against NGH and an agenda that emphasised NGH’s disadvantages in comparison with its rivals in terms of its site re-development and maintenance problems.

The participants were however acutely aware of the external support for NGH. They realised that any action taken to completely close the site would send political shock waves around the city. The University tried to remain impartial at this workshop as it had a vested interest in maintaining access to all clinical specialities in order to sustain its research activities and medical training. It was a prestigious and long-established member of the medical community, and carried considerable influence. In an attempt to appease the NGH and its supporters the University introduced Option 6, which would not completely close the site. Option 6 proposed:

“The existing acute hospital services will be largely concentrated at RVI and Freeman with major service and site rationalisation and new style services based at NGH with a strong primary/community based focus - a hospital for the 21<sup>st</sup> century.” [92:1]

One senior academic who was present at the workshop observed:

“People at the University supported the merger because we felt it was the best solution. In terms of delivering health services in a city this size you can’t really afford to have a disjointed arrangement of services. We needed to take into account community and tertiary services. Option 6 seemed like a workable solution.”

The RVI and the Health Authorities supported this option. In selling this option to the Review Group the University was acting strategically as a broker, presenting itself as neutral and as trying to mediate between the opposing camps, in order to help keep the peace. The workshop decided that there should be a public consultation and that a more detailed assessment by key stakeholder groups of the proposed changes should

be submitted to the public during the consultation period. The purpose of the consultation process was to allow all the relevant stakeholders to submit comments and critiques before the final document was drafted. The Newcastle DHA and the RHA would consider these reports before any final decision would be made [94].

At the workshop, the RHA also encouraged NGH to proceed with its second Trust application, which was submitted in April 1993 [96]. This is seen as a continuation of the RHA's strategy to be perceived as a neutral party.

Following the Seaburn Workshop many of the senior staff, including the CEO, left NGH. The consultants however continued to wage war against the RVI and tried to muster support to keep NGH open as an acute care provider.

### **5.11 A New Incoherence in the RVI's Direction of Change**

The Acute Services Review Group now renamed itself the Newcastle Implementation Steering Group, chaired again by the CEO of the Newcastle DHA [188]. This choice of name is interesting, as it suggests that Option 6 was no longer just an option to put out to consultation. The Implementation Steering Group appointed seven working groups, each to submit a report to be incorporated into the final draft of the strategy document for public consultation [158]. The two most important groups for present purposes are described below.

The Clinical Service Configuration Group was to deliberate on a distribution and configuration of specialities and clinical support services, principally between the RVI and Freeman, in conjunction with the proposed shape of the new services at NGH [100]. In essence it was trying to appease all of the key stakeholders who would be affected by these changes: the hospitals, the medical community, the University and the RHA [100]. The Group was unclear about lines of accountability, whether there were any extra funds available to help with the transition and the time frame for change. The Group considered that this lack of information and the inadequate communication between these stakeholders and the RHA was an indication that the time frame was unrealistic and that the RHA was not really aware of all the issues that

had to be taken into account when merging and relocating medical services across sites. In short, the RHA had grossly underestimated the complexity of this task [187].

The role of the NGH Vision Group was to develop a new model of service delivery for the NGH site. It would seek to define what was referred to as “new style” hospital and to understand the service demands of both the community services sector and primary care. The Group needed to be informed about which acute services would remain on site at NGH, which acute services would be moved to other sites and who would be responsible for managing the site [184].

Both these groups struggled because of this lack of important information. The issues that these groups highlighted would remain politically contentious areas and develop into major hurdles during the post merger integration phase. The change process was now seen to be lacking certainty and coherence and had the potential to cause conflict among the actors who had supported Option 6.

## **5.12 Public Consultation: More Agenda-Setting**

Newcastle Health Authority published its proposals, ‘The Future of Health Care in Newcastle’ on 30<sup>th</sup> June 1993 and commenced a three-month period of formal public consultation [215]. This consultation document was a booklet, the body of which ran to 20 pages. It outlined changing trends in health care resulting from several factors including advances in medical technology and health care practices, and greater public awareness and demands, and highlighted the need for improvement of the way primary care, community services and hospitals worked together.

The document outlined the six Options considered at Seaburn. It noted that many services were duplicated across the three hospitals. Backlog maintenance figures showed that the costs to bring the hospitals up to standard were: Freeman, £5m; NGH, £20m; and the RVI, £23m. The document highlighted that the hospitals were facing increasing financial pressures and that other priorities were emerging – continuing care for the elderly and those with mental health problems and learning difficulties.

The consultation document stated that all but Options 4 and 6 were unacceptable, and that Option 6 was preferred over Option 4 (which also would close NGH but with no plans for re-use of its site). It did not refer to the issues raised in the stakeholder submissions that had been received in opposition to the closure of NGH. Furthermore, although it was expressed to be a proposal developed by Newcastle Health Authority working “in partnership with” NGH and the other Review Group members, the document did not mention the alternative proposal that had been put forward by NGH. The document stated:

“During the four months of the review, extensive discussions were held with representatives of hospital doctors, GPs, and the public. External consultants carried out an analysis of finance, building use, and projections for the numbers of patients treated and how long they stay in hospital. This work formed the basis for identifying and assessing possible options.

Although the review started as an examination of acute services, it became clear from the feedback from the public and GPs that we needed to do more than just re-organise hospitals.

Improving the way primary care (provided by GPs and their support staff), community services, and hospitals work together will provide a much better opportunity to meet the concerns and health needs of local people as we move into the next century.

The proposal in this document has already gained support from the health professionals involved. Now Newcastle Health Authority wishes to consider as wide a range of views as possible before any decision is taken about the best way forward.” [215:4]

The suggestion that *all* health professionals involved had support the proposal in the document was plainly incorrect and misleading, and discounted entirely the views of the many who did not support the proposal, including the NGH medical staff.

In framing the consultation document in the manner described above, the RHA was once again setting the agenda for discussion, and closing off other options that would enable NGH to survive as an acute hospital. The document’s emphasis on the involvement and approval of the health professionals involved is also a further example of the tactic of inducing others to believe that others are in control, thereby avoiding being the target for any backlash.

To support the consultation process 5000 copies of the consultation document were distributed and 60,000 summary leaflets printed. Newcastle Health Authority held public meetings in 19 districts throughout the city from 14 - 29<sup>th</sup> July and 2 - 30<sup>th</sup>

September 1993. Health professionals organised several structured professional discussions among themselves. The CHC organised 26 special needs and focus groups. The Newcastle Health Authority's CEO, or its Director of Public Health, led the public presentations [185].

The public meetings were poorly attended and it was recorded that attendance varied from as few as five people to a maximum of 40 [186]. Among factors identified by the Newcastle DHA as contributing to the poor attendance were poor publicity, the fact that these meetings had been scheduled over the summer period when many people were on vacation, and the lack of crèche facilities at many of the meetings [187].

Key agencies and individuals from throughout the city, including the CHC, Newcastle City Council, Newcastle Council for Voluntary Service, GPs, Medical community and the University, were invited by Newcastle Health Authority to work independently but in co-operation with the Authority, to debate the proposals. Throughout this consultation period, the only stakeholder group to work in collaboration with other groups was the CHC. The CHC recognised the need to try to lessen the impact of one important aspect of the RHA's, the possession of information and evidence relating to the proposals. As one Community Stakeholder observed:

“It was important for us to meet with as many groups as we could. We wanted to get our own information and evidence or we would have been forced to rely on everything the health authority was presenting.” (Community Stakeholder)

There was a political divide between the RVI and its supporters and the rest of the health care community on how to reconfigure acute care services in Newcastle. There were strong views in the health care community as indicated by the following comments:

“This health service review and initial merger proposal was just a political excuse to take money out of the system and to reconfigure services and NGH didn't have a chance against the other key players. There was too much at risk. Mergers were about expansion and bigger budgets and scoring brownie points with the government not patient care.” (Senior Hospital Clinician)

“NGH wasn't powerful enough to win the war but at least it was prepared to wage war against its opponents.” (Health Authority Manager)

“The community knew that this battle was not about merging services but about who would take over the NGH services and staff, the consultation process was a waste of money.” (Community Stakeholder)

## 5.13 Stakeholder Values and Interests Articulated Again

The responses of the key stakeholder groups are summarised below.

### *The Royal Victoria Infirmary*

The general view of staff and management was that the task ahead was extremely complex and that there were many uncertainties inherent in the Acute Services Review.

“Merging clinical services is one thing but bringing staff from different sites together to work is another.” (Hospital Manager)

“They kept telling us no one will lose their job but I’m not convinced. How can you have so much change and still keep all the staff.” (Hospital Clinician)

Money was being taken out of acute care and re-directed into the development of primary care. The District Health Authorities represented at the Seaburn workshop told the Trusts that there would be £20 million less each year to spend on acute hospital care [149]. With this size of financial funding reduction the continued provision of acute hospital services on three sites looked unaffordable. The RVI’s view was that competition between the acute hospitals would be destructive and wasteful. This would only lead to bankruptcy and major disruption of services.

The RVI was concerned by a modification that had appeared in the consultation document, that all out-patient services and day case activity should be based at NGH. This modification was seen by some interviewees as an attempt by the DHA, from a public relations perspective, to soften the impact of the changes to the NGH site by suggesting an ongoing hospital presence through the use of the term “Outpatients”.

“It was all a sham, deception. Somehow the RHA wanted to create this illusion that the hospital still had a presence in the West End. This was their way of trying to appease the public. The General consultants knew this wouldn’t happen so they quickly crossed over to the other side and joined their colleagues at the RVI and the Freeman.” (Senior Hospital Executive)

### *The University*

The University believed that it was essential for research, clinical development and undergraduate teaching that there should be a correct distribution and critical mass of

general surgical sub-specialities across the two sites [90, 91, 114]. The present proposal would create a gross imbalance of such services that would lead to a cessation of surgical research and impairment of undergraduate teaching at the RVI [87]. It recommended that this re-distribution of services be re-evaluated.

From a research perspective, the amalgamation of some services on specific sites would increase both the facilities and opportunities for research.

“In terms of academic endeavour – merger across sites makes sense. You can’t teach and conduct research very effectively if the participants are in one half of their life competing with one another and in the other half of their life collaborating with each other in research.” (Senior Academic)

A hospital consultant who was also actively involved in medical research with the University gave this further insight:

“Doctors see mergers from another perspective. We have a different agenda. We can actually pool resources and get on with our research. We can see working as a united department or services as a way to get this done.”

### *The Medical Community*

The NGH medical staff were totally against the proposals for many of the same reasons as the CHC while the Freeman medical staff wanted to move the changes forward sooner rather than later [71, 75]. The RVI consultants were non-committal because they knew that the proposed changes could have an impact on their speciality location, budget, staffing compliment and even their own jobs .

“The problem for both the RVI and the Freeman consultants was that there was a lot of bickering about who would get what services and who would be in charge of who, and who would take leadership of what service.” (Community Stakeholder)

However, from a medical and clinical viewpoint, the majority of the medical professionals in Newcastle were in agreement as to the clinical and medical issues that needed to be taken into consideration if acute and outpatient services were to be re-located and that the Health Authorities and hospital managers promoting Option 6 did not appreciate the complexity of these issues [87].

The Consultant group at NGH was vehemently opposed to the service stripping and closure of NGH.

“Many of the medics felt that patient care was never the issue it was all about power, politics and conquering the other side. Winning was everything and it had to be achieved at all costs.” (Senior Hospital Executive)

The following expresses a commonly held view among the consultants:

“the rationale behind the decision to close NGH was based upon back room politics and that the University wielded a big stick. The medical school was ultimately concerned about its status and the hospital’s ability to support and fund their research. Even though the NGH choice made more economical sense, the RVI still had the historical prestige of being attached to the medical school whereas NGH was still regarded as the poor relation.” (Senior Hospital Clinician)

### ***The Newcastle General Hospital***

NGH’s senior management, consultants and staff conducted a vigorous “Save the General Hospital Campaign”, which was funded by many of the consultants personally. The hospital had the support of the CHC, Newcastle Upon Tyne City Council, many GPs within the Tyneside area and 104,000 signatories supporting a petition to be forwarded to the Secretary of State [181, 187]. NGH drew attention to the fact that many of the objections raised during the consultation period still had not been fully addressed, such as the projected revenue savings that would be achieved by the amalgamation of services on the RVI site. The consultation document had not addressed how the services remaining on the NGH site would be managed, and none of the staff in the targeted departments had been consulted .

“Of course the NGH wasn’t consulted. They didn’t hold the power. The University, the RVI and the Freeman had it all mapped out. And the NGH wasn’t privy to any of those discussions.” (Senior Hospital Clinician)

### ***Community Health Council Rejects the Proposal for Change***

The CHC was concerned that the DHA was trying to rush a decision on a very complex process that would impact on all NHS services in Newcastle, and that other options needed to be considered and accurately costed before any decision should be made. Many of the public focus groups shared the same concerns:



“during this consultation period people were expected to make decisions about very complex issues with very little information and in a very short time period. It was frustrating if you needed further details but even more frustrating when you didn’t know who to ask for that information. There didn’t appear to be anyone in charge and certainly no one who was willing to take the responsibility. As for costings, the government had tunnel vision. All they thought about was how much money they could save and never stopped to think how much this just might cost instead.” (Community Stakeholder)

The CHC fully supported NGH in its bid to retain its status as an acute care provider. It raised the point that at no time were the RVI or Freeman considered for a different role and questioned whether the debate regarding the best location for services had been adequate [187].

The CHC was concerned that a more detailed description of the site development should have been made available for public review along with costs. It also considered that in light of these many unanswered issues the DHA should have extended the consultation period [187]. The CHC adamantly rejected both the consultation process and the recommendations put forward for health care reform in Newcastle, and would put its case forward to the DHA.

#### **5.14 Missing Critical Information**

Although the stakeholder groups worked independently, many had identified common issues in their respective reports submitted to the DHA. These were as follows: (i) the consultation period was too short; (ii) the report lacked adequate detail and important financial information; (iii) there was no time-scale regarding the implementation of the proposed changes; (iv) the calculated reduction in acute bed numbers might have been excessive and (v) it was imperative that there be extensive discussion, consultation and planning before any clinical services were transferred between existing sites [80, 81, 82, 91, 101, 105].

The lack of detail in the proposal made it difficult for the stakeholders to assess the impact these changes would have on patients, costs and resources available, service reconfiguration, staffing, and treatment accessibility. A clear service development plan should have been available to at least inform the stakeholders what they could expect as baseline community and primary health services .

“Initially this consultation exercise was supposed to be about reducing acute care capacity and saving money in Newcastle. The plan to turn the General into a site for chronic care, services for the elderly and mental health was a decision made behind closed doors - so it’s no wonder there was no written formal plan. The arrangements were still being negotiated with the powers that be.” (Senior Trust Executive)

The consultation document had failed to provide the necessary financial information on the availability of capital, which made it difficult for some stakeholder groups to adequately evaluate the proposed service changes. Since the aim of this exercise was to rationalise services because of decreased government revenue, there should have been some financial forecast as to what the proposed changes might cost in relation to the existing service configuration. It was an open question whether these service changes would result in any cost savings [88, 183, 187].

The expected time scale of the proposed changes was not made public at this stage of the consultation. Many considered that the consultation period was too short in view of the complexity of the proposed changes. The University response stated:

”the whole process could be a recipe for disaster coupled with the many changes taking place in NHS. It’s a slippery slope which could easily lead to financial destabilisation if these proposed changes are not carefully planned and phased in over the long term.” [88]

The DHA was giving mixed messages about admission numbers. It predicted a slight increase in the number of acute patients requiring treatment despite the bed cuts [117].

It was clear from the consultation exercise that many stakeholders had raised numerous legitimate concerns about the proposed changes. Some went further and accused the RHA of presenting information to the public which it knew to be misleading. Several stakeholder groups believed that the information in the consultation document and the information presented by the DHA at the public meetings varied, and did not reflect Option 6 as formulated at the Seaburn workshop [187]. This was a serious allegation but was in fact supported by interviewees from the RVI, the Freeman and the CHC .

“In actual fact , there were major discrepancies between what was agreed on at Seaburn and what the DHA was selling to the general public. They had become a law unto themselves. This kind of politicking would only confuse the issues and could back fire to the detriment of all involved.” (Senior Hospital Executive)

The withholding of critical information was therefore seen by many stakeholders as a deliberate tactic used by the RHA to reinforce its coercive control of the restructuring of local hospitals. This tactic is part of the wider tactic used by skilled actors as described in the next paragraph.

### **5.15 Isolation of the RHA's Opponents**

A number of interviewees expressed concerns about the RHA's handling of the review process generally. The consultation process was ostensibly an exercise whereby the community and Health Authorities would work together in developing health care reform initiatives. Having asked stakeholders to identify concerns about the proposed changes and provide feedback, the RHA, DHA and the Secretary of State might have been expected to consider those concerns fully and openly. However, there had been no formal debate or discussions between the Health Authorities and the health community. Discussions were held with individual groups behind closed doors and at no time were the different stakeholder groups given information about the position or views of other groups across the health care community. It appeared that the RHA had chosen to ignore stakeholder submissions, and made no concessions to stakeholder concerns.

“Let's face it – it was very clear when the Secretary of State just ignored the report submitted by the CHC. The writing was on the wall. This had been the government's intention all along. So much for transparency.” (Hospital Manager)

Ultimately each stakeholder group was concerned about how the proposed changes might affect its own interests, particularly its ability to function in the long term as money was becoming a scarce resource. Some stakeholders found it difficult to wholly support either of the NGH or RVI camps. None of the stakeholder groups attempted to work together or submit joint reports, and perhaps may not have been aware or confident of the potential advantages of concerted action. Importantly, the RHA was careful not to become the node of a network for them and avoided communicating the views of one group to other groups. NGH and its supporter groups were all isolated outliers and, as Fligstein (2001:115) observes:

“If they are upset and even if there are a number of upset but isolated actors, they generally remain disorganised. Since these types of actors are usually incapable of strategic action themselves, they remain isolates”

Here we see one of the factors explaining why NGH was losing the battle.

The DHA had a statutory responsibility to consult with the CHC over its proposals for any ‘substantial change’ of service [12]. When the CHC decided to oppose the recommendations put forward in Option 6 of the consultation document, the matter was referred to the RHA for a further decision. The RHA supported the DHA but the CHC still opposed the recommendation, and so, as required under statute, the proposal was referred to the Secretary of State in November 1993 for a final decision.

### **5.16 Another Key Turning Point**

On 9th December 1993 the RHA informed the CHC that the Secretary of State had agreed that the Newcastle DHA should proceed to implement Option 6 of the Acute Services Review, regardless of the issues raised and opposition from key stakeholder groups. This was another key turning point in the case and marked the end of NGH’s application for Trust status, which did not reach the consultation stage. As one hospital consultant interviewed put it:

“By denying NGH Trust status, the message from the government couldn’t be more clear – this was the end of the General as we knew it.”

The Secretary of State at the same time authorised the RHA to proceed with a public consultation on the proposal to create a new Newcastle City Health NHS Trust that would be located on the NGH site [192]. This new Trust would be formed from a merger between two of the members of the Acute Services Review Group, Newcastle Mental Health Trust and UnityNE Health and would also incorporate part of NGH’s services. (That merger is not included in this research.)

### **5.17 Hospital Restructuring and Service Reconfiguration**

The Secretary of State decided that the Newcastle DHA would assume the role of monitoring and managing the implementation process, which would commence on 1<sup>st</sup>

April 1994 [20a]. The first phase of the implementation plan focused on the reorganisation of management and clinical responsibility for acute services at the RVI and on the NGH site, supported by the transfer of employment of medical, nursing, professional and managerial staff directly responsible for these services [20a]. Most of the clinical services at NGH would be managed by the RVI [154].

The Secretary of State's decision to support the recommendations of the ASR and to reshape health services in Newcastle would have major restructuring and financial implications for the RVI and to a lesser extent the Freeman. The NGH site would see the development of a new style community and primary care based Trust [194]. The value of the assets to be transferred to the RVI had been assessed at £8m while the contract income generated by these services was valued at £42m. The Freeman was estimated to gain contract income around £7.5m [154].

The RVI would now be required to dissolve its present Trust status in order to establish a new Trust reflecting the take over of NGH's acute services, and would have to conduct another consultation process for these changes [151]. The changes affecting the Freeman were not of sufficient scale as to require the dissolution of the existing Freeman Trust and formation of a new Trust, but responses would be sought as to the reconfiguration of the Trust [154].

The new RVI and Associated Hospitals NHS Trust was established on 1<sup>st</sup> April 1994. The Freeman inherited the Regional Cancer Services from NGH and other key clinical services were to be transferred at a later date depending upon the hospitals capital investment plans. The new Newcastle City Health NHS Trust was established on the former site of NGH and was to be responsible for the management of any remaining NGH clinical services.

## **5.18 Existing Values Continue**

The RVI Trust Board would have overall corporate responsibility for restructuring the Trust. The Trust Board was made up of five executives and five non-executive Directors led by a non-executive Chairman. The Secretary of State appointed the non-executive members to the Board. The membership of the RVI Board remained virtually the same from 1991 until 1997. There were no changes in the Board composition when NGH was taken over. The RVI's mission statement also remained unchanged following the revision of its Trust status in 1994 (RVI Annual Reports 1991 – 1997). It can be seen that the process of restructuring acute hospital services did not reflect an archetypal shift within the RVI.

The Trust Executive Group's first task would be to provide project direction for the planning and implementation of the ASR [173]. It would be given the power to interpret Trust policy, make decisions on behalf of the Board and oversee the development of new clinical directorates. This Group would be recognised as the authoritative reference source on the ASR. The membership of this Group was important because it had representation from the RVI, NGH, Hexham General, the medical executive committees from each site and nursing [162e]. The Chairman of the Group would be the CEO of the RVI.

## **5.19 Scale of Change in RVI: Structural Adjustment**

### ***Middle Management***

The RVI senior executive structure in 1991 had seven Director positions. When the Secretary of State announced that the RVI would be taking over the management of the acute services from the NGH, the RVI's CEO decided that a transitional management structure would be put in place [145, 162e]. The major structural changes within the RVI would take place at the middle management level. This was in direct response to the introduction of the clinical directorate system and the absorption of

NGH's clinical services [162c]. These new structural changes were implemented in 1995 [171].

By 1997 organisational structure was more streamlined than the previous versions and consisted of four executive directors and the Clinical Director of each Directorate, with a new tier consisting of six Heads of Department directly accountable to the new Deputy CEO [214]. There were no less than four different management structures at the RVI in the period from 1993-97, as shown in Figures 5.4 - 5.7.

### *Clinical Directorates*

A new Clinical Directorate structure was implemented to re-design existing services by merging clinical areas and developing a "streams of care" model [202]. The number of clinical directorates would be reduced from 21 to a manageable 8. Individual subspecialty groups would be defined and designated as Departments (see Figure 5.8). Heads of Department would have responsibility and authority over their staff and would be accountable to their respective Clinical Directors.

The creation of clinical directorates saw a major shift in power held by the medical profession in their roles as clinical and medical directors. There was a feeling among the profession that through the introduction of the internal market they had lost control over the flow of patients and resources but that through their new management role they had regained some of that lost power by having budgetary control of clinical directorates (Ashburner et al., 1996). However, most clinical directors believed that the time demands of their new administrative roles in addition to their on-going clinical, teaching, research and medical supervision commitments, far exceeded the number of hours in a day, and many considered that they were unable to fulfil their professional obligations.

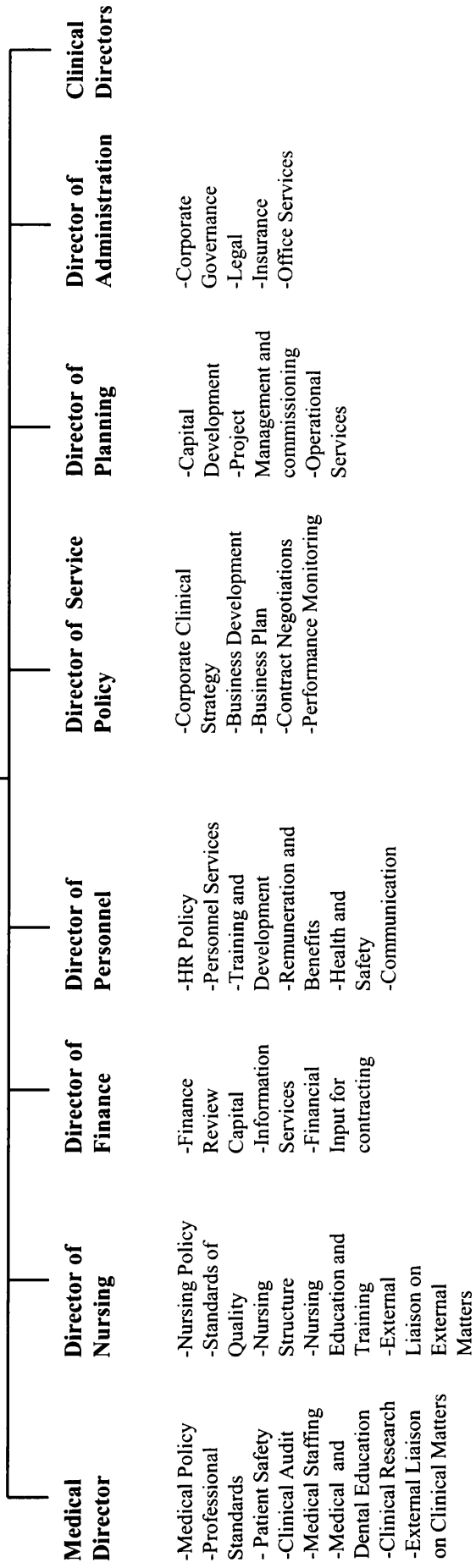
"The workload had become ridiculous. I was financially and clinically responsible for this new clinical directorate. As Directors, we were expected to teach, conduct research, maintain our clinical practice, supervise fellow clinicians and sit on the Board. Something had to give." (Senior Hospital Clinician)

Their workloads had become unmanageable and would only get worse as the service integration progressed.

**Figure 5.4: Royal Victoria Infirmary & Associated Hospitals NHS Trust - Organisational Structure May 1993**

**ROYAL VICTORIA INFIRMARY & ASSOCIATED HOSPITALS NHS TRUST**

**SENIOR EXECUTIVE STRUCTURE**



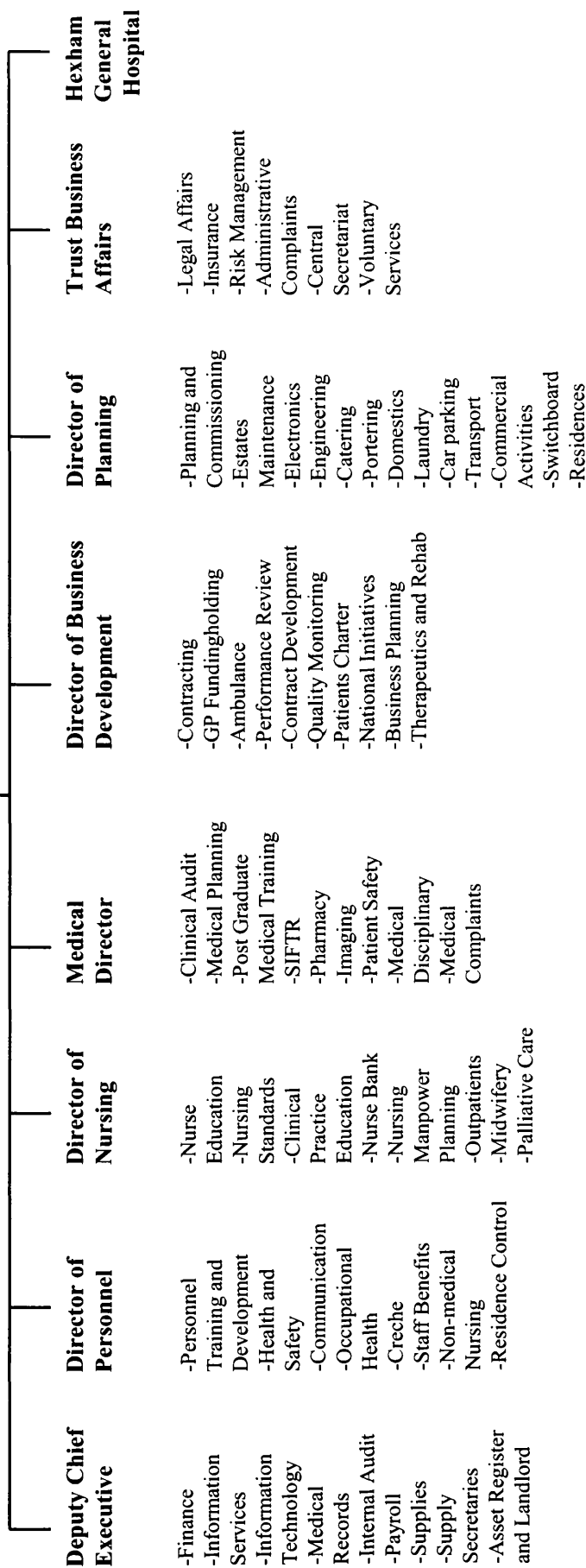
The Clinical Directorate structure will be reviewed by the Medical Director and will be the subject of a later paper to the Trust Board



**Figure 5.5: Royal Victoria Infirmary and Hexham General Hospital Proposed Interim Structure 1993-1994**

Proposed Interim Structure

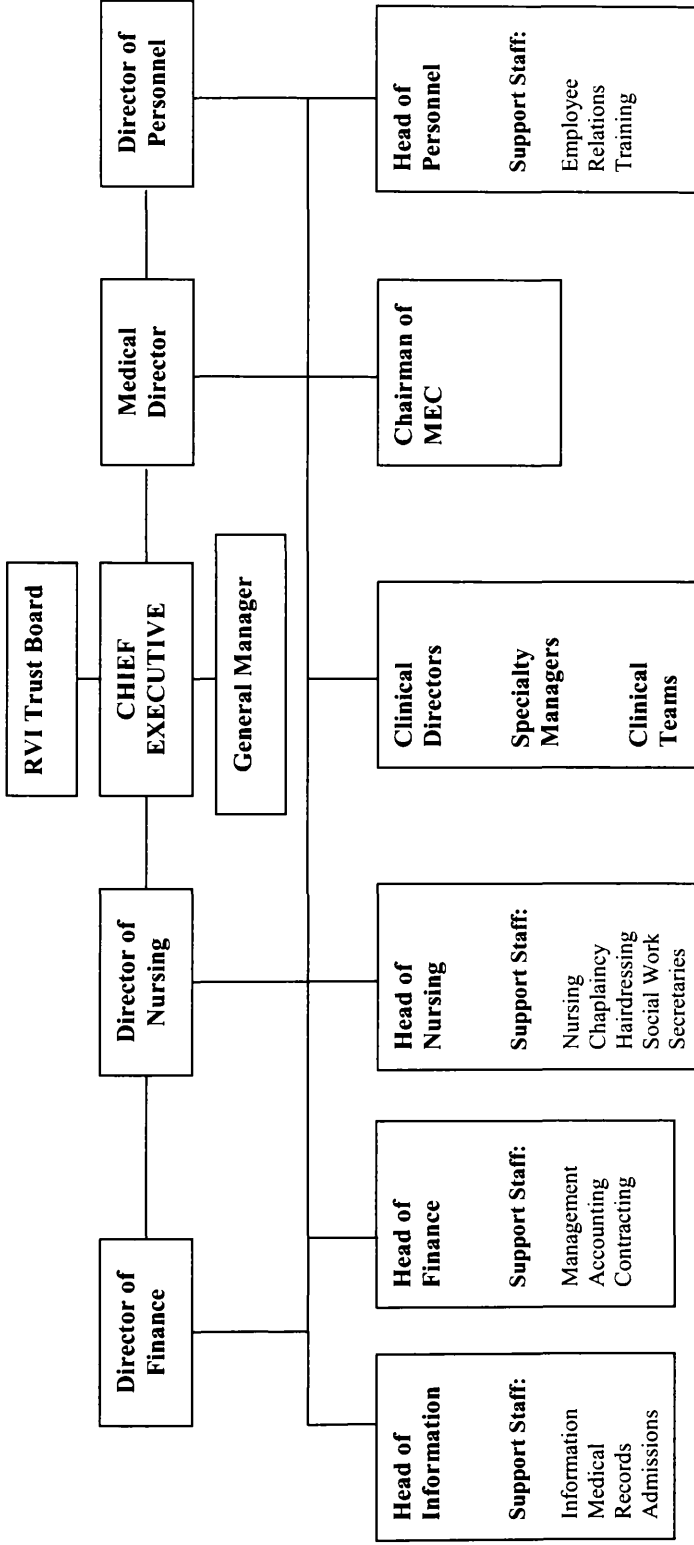
CHIEF EXECUTIVE



Source: Royal Victoria Infirmary & Associated Hospitals NHS Trust, Management Structure, A Discussion Document, December 1993

**Figure 5.6: Royal Victoria Infirmary, Hexham General Hospital and Newcastle General Hospital – Merged Transitional Structure 1994**

**NGH/RVI Management Structure**



Source: Royal Victoria Infirmary & Associated Hospital NHS Trust, Management Structure, Trust Board Minutes, 19 April 1994

**Figure 5.7: Royal Victoria Infirmary & Associated Hospitals NHS Trust  
Directorate Structure and Speciality Departments 1995-96**

**MEDICAL DIRECTORATE**

General Medicine  
Haematology  
Dermatology  
Infectious Diseases  
Nephrology  
Care of the Elderly  
NCIU

**SURGICAL SERVICES DIRECTORATE**

General Surgery  
Ophthalmology  
Orthopaedics  
Oral Surgery  
Plastic Surgery

**CHILDRENS SERVICES DIRECTORATE**

Paediatric Surgery  
Paediatrics

**WOMENS SERVICES DIRECTORATE**

Obsterics  
Gynaecology  
SCBU

**NEUROSCIENCES DIRECTORATE**

Neuro Surgery  
Neurology

**CLINICAL SUPPORT SERVICES DIRECTORATE**

Adult I.T.U.  
Home Ventilation  
Pain Management

**DIAGNOSTIC SERVICES DIRECTORATE**

Laboratory Services  
Radiology

**DENTAL DIRECTORATE**

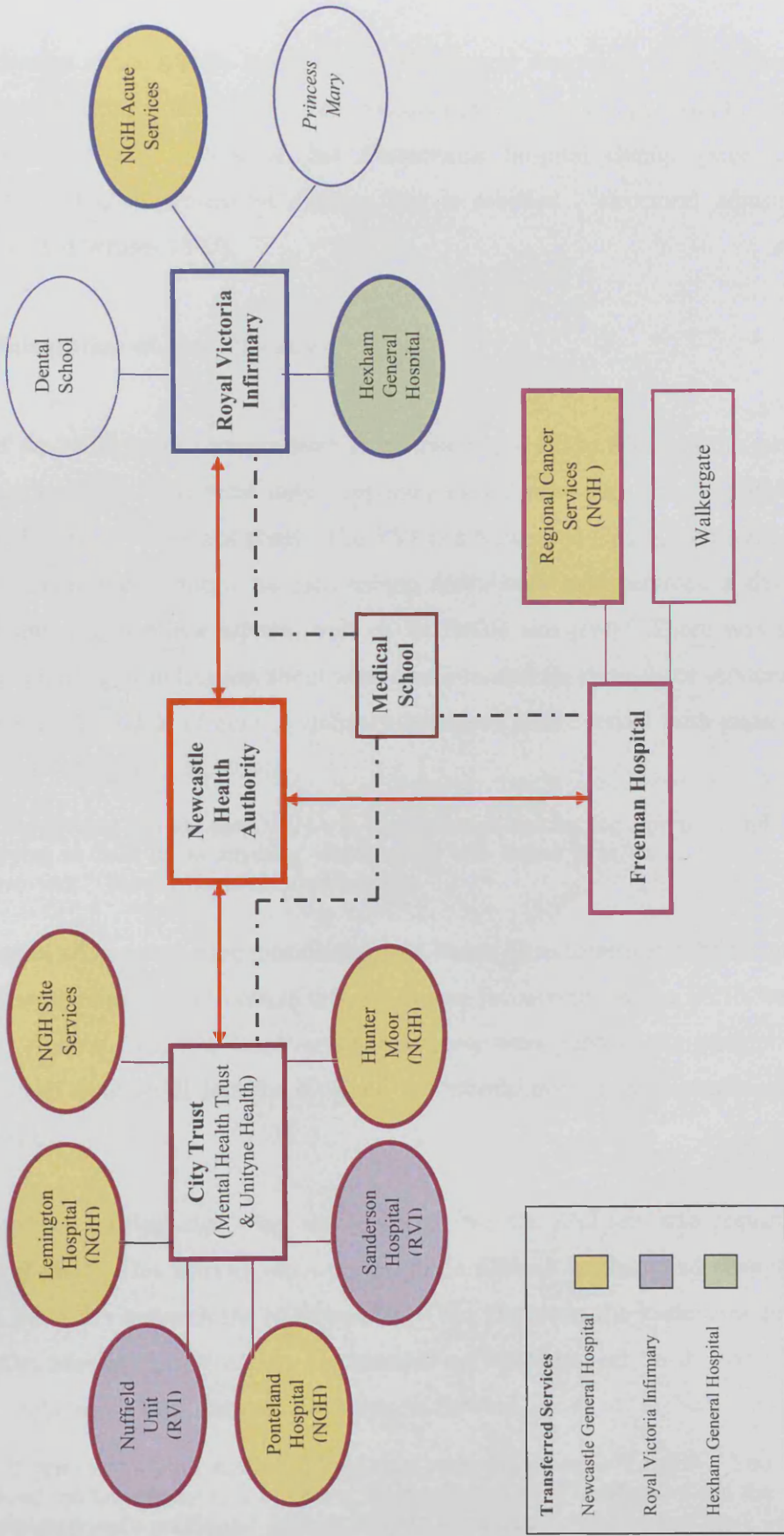
Periodontology

**HEXHAM GENERAL HOSPITAL**

General Surgery  
Orthopaedics  
Oral Surgery  
General Medicine  
Care of the Elderly  
Obstetrics  
Gynaecology  
Anaesthetics

Source: RVI Annual Report, 1995-96.

Figure 5.8: Newcastle Hospital Configuration Post Acute Services Review, 1995-1996



Source: Author

These changes at the middle management and clinical directorate level characterise the change occurring within the RVI as a result of the merger as a pattern of relatively minor and structural alterations that characterise hospital change prior to the introduction of transformational change: this is labelled ‘structural adjustment’ (Kitchener and Whipp, 1997).

## **5.20 Integration of Acute Services**

Many of the NGH acute services were to be transferred to the RVI and the few that were transferred to NGH were only temporary moves until such time the RVI had completed its re-development plans. The RVI and Newcastle City Health NHS Trust were reviewing their options for establishing ambulatory care services, a day case surgical unit and a minor injuries unit on the NGH site [194]. There was still a substantial degree of indecision about what was intended for these three services, and these proposed models of service delivery remained controversial with consultants across Newcastle [81, 82, 87, 89, 91].

“It appeared that the new NGH was an institution looking for a purpose and trying to hold on to anything which might still define it as an acute care provider.” (Senior Hospital Administrator)

These issues arising out of the introduction of Clinical Directorates and the integration of acute services are seen to create difficulties and incoherence in the RVI’s track of change. Against this, two major areas of success were seen in the integration of medical staff from NGH into the RVI and the introduction of project management department.

The in-patient services that were amalgamated into the RVI site also required the transfer of staff. This activity often proved to be difficult as there had always been feelings of rivalry between the NGH and the RVI. However, the leadership qualities of the RVI Medical Director, who commanded universal respect in the local health services field, moved the reconciliation process forward.

“If you can rally the medics and get them on board, others will follow. You need the knowledge of a clinician, the determination of a salesman and the diplomacy of a politician.” (Senior Hospital Clinician)

In this approach by the Medical Director we see, at the level of key individual actors, another example of social skill: to find a way to join actors or groups with widely different preferences and help reorder those preferences.

“Once a number of actors come on board, then others will follow..... This is most frequently done by trying to create a common collective identity (Ansell 1998). Such an identity allows groups to attach their divergent senses of their interest to a common project” (Fligstein, 2001:114-5)

The new hospital configuration in Newcastle resulting from the ASR is shown in Figure 5.14.

### **5.21 Towards Transformation: Project Management**

Another new aspect of the management re-structuring was the introduction of a Project Management Department to co-ordinate and supervise the transfer of clinical services [213]. The Trust had been experiencing problems with project management because it was poor at managing process [57d]. One major shortcoming was:

“the Trust failed to realise the complexity and the amount of work involved when trying to carry out these change projects. They should have appointed a project management team from the very beginning” (Hospital Clinician)

A commonly held view was summarised as follows:

“the culture of the hospital was to solve problems as they occurred not to manage long term preventative processes. The Trust had no framework within which projects should have been managed nor did they have the skill base or discipline required for effective project management.” (Senior Hospital Clinician)

A key role of this new Department was to ensure that any request by a department for funds was supported by a convincing business case. This was an entirely new, business-oriented ethos for a public sector hospital at this time. Whereas the other aspects of restructuring and integration discussed above are seen to be attributable to the acquisition of NGH’s acute services, the introduction of the Project Management Department was an indication of the adoption by the RVI of a more private sector oriented approach to structures and systems and is compatible with a movement over the long term toward transformational change in the RVI.

## 5.22 Financial Pressures

Over the next few years there would be a change in the way NHS money would be distributed. Newcastle could expect to have a total budget reduction of approximately £20m each year over the next five years, while the NHS was expected to invest at least £10m each year in primary care during the same period. It was estimated that savings of over £30m each year would be achieved through the re-organisation of hospital services in Newcastle [167].

Additional financial pressures, hospital debt and overspend, government fiscal constraints, reallocation of scarce revenue and backlog maintenance costs were placing a very heavy burden on Newcastle. The RHA had intended that a merger between Trusts would reduce many of these pressures by reducing overheads and expenses and that the economies of scale could be successfully achieved.

However, it was becoming increasingly clear that the merger process was much more complex than anticipated and that the financial cost of merging several Trusts had been greatly underestimated [162b]. By the end of June 1994, only two months into the merger, the RVI was already experiencing an income and expenditure over-commitment in excess of £600,000 (RVI Annual Report 1994/95). A further difficulty was that the monies originally promised by the government to re-develop health care services across Newcastle were around £63m but the government now changed its mind and set a ceiling of between £30-40m. This substantial and unexpected reduction of capital monies available meant that the acute services re-configuration plans would have to be drastically revised and down scaled [35c]. In a major twist along the RVI's path towards transformational change, the RVI Board decided that the only way to move the Acute Services Review and restructuring agenda forward would be to embrace the PFI Scheme and to apply to the Exchequer for fast track funding. The fast track scheme would provide £8.37m and the PFI schemes would provide £39.56m. The ASR would now involve a capital investment in the order of £47m across the city [62]. The financial reality and strain of implementing the Acute Services Review change initiatives was starting to show.

### 5.23 Summary

We see the restructuring of the hospital field in Newcastle and also the changes occurring at the hospital organisation level as a process dominated by the purposeful use by one key actor (the RHA as agent of the government) of its power as the ultimate source of funding for the field. In its use of this power we have seen how the RHA, rather than risk political flack by directly closing NGH, employed several tactics used by socially skilled strategic actors to covertly force the NGH into closure as an acute hospital.

Some actors (NGH consultants and NGH itself) resisted the field-level changes that they did not agree with (closure of NGH as an acute hospital) but did not have sufficient power to overcome the political alliance of other actors against them. This was in part due to the lack of any well-organised alliance with other actors who supported them (CHC, City Council, Member of Parliament, the local newspaper and the public).

Other actors in the field (the RVI, the Freeman, the University, DHAs and non-acute hospital Trusts) espoused the RHA's change agenda because they perceived that their interests would be served by doing so.

The case highlights the significance of taking into account the local variants of an archetype, which can be discovered and understood by relating them to their organisational and institutional contexts (Kitchener, 1998:4; Dent et al., 2004:738). These local variants will include the political relationships between key actors which may not be based on concerns for market efficiency: NGH had a strong case for acute hospital Trust status but was not allowed the opportunity to prove this in the internal market.

NGH itself followed an abortive track of change notwithstanding its clear reformative commitment. This is explained by the RHA's control of the change process through the use of its power. There was reformative commitment within NGH, which would precipitate change. NGH also had the "capacity for action" to enable radical change: there was no evidence in the data that NGH lacked any of the understandings, skills



and abilities necessary for successful operation as a Trust hospital. However, NGH did not have the other necessary enabling factor: supportive power dependencies. Greenwood and Hinings (1996) acknowledge, citing Fligstein (1991:313) that “Change....can only occur when either a new set of actors gains power or it is in the interest of those in power to alter the organisation’s goals”. If the RHA had allowed NGH to obtain Trust status, then a new set of actors (the Trust Board) would have gained power.

In the case, the RVI followed a track of change that can be seen as structural adjustment following acquisition of NGH’s acute services while at the same time pursuing transformational change (from DMH to Trust hospital) over the longer term. As at the end of our case the RVI was struggling with both external (financing) and internal (managerial) difficulties and was experiencing a degree of conflict and incoherence reflected in the concerns of groups within the RVI and the Freeman about how the restructuring was handled by the RHA and the consequential uncertainty as to how the changes would affect them.

## CHAPTER 6

### THE ONTARIO HOSPITAL CASE STUDY: THE RESTRUCTURING OF ACUTE CARE HOSPITALS IN HAMILTON

#### 6.1 Introduction

This case study research seeks to provide an understanding of how changes occurred in hospitals in Hamilton in the period after December 1995 when the Ministry of Health (MOH) introduced Bill 26 (later to become the Savings and Restructuring Act) and announced that hospital funding would be reduced by 18 percent over the next three years. Overall health care spending in Ontario was to be held at \$17.4 billion, and the \$1.3 billion expected to be cut from hospitals would be re-invested into further development of the community health services sector [12]. This Bill gave the Minister of Health unprecedented statutory powers to bring about system-wide change. These would include powers to allocate funding, direct hospital operations and regulate physician privileges [13].

A case narrative methodology was chosen for the reasons stated in the Methodology (see Chapter 3). In analysing the processes of change that were observed, the study draws on Greenwood and Hinings' concepts of archetypes and tracks of change together with Neil Fligstein's synthesis of conceptual insights into organisational fields, power and social skill. The changes proposed by Bill 26 clearly created the potential for altered domains of activity for health services providers and thus potentially elements of new or modified interpretive schemes. The concept of archetype is used to define the nature and scale of change in the hospitals under review, i.e. whether change is consistent or not with a move between one coherent pattern of organisation and a new one, and whether change can best be described as incremental or quantum movement. Organisational transformation may be analysed not only at the level of a single hospital organisation, but also at the level of the organisational field (Ferlie, 1999): in this case the health care sector in Hamilton. Greenwood and Hinings (1996) recognise that it is at the organisational field level where we can both identify the normative contextual pressures that maintain stability and locate the dynamics of change. However, in considering both precipitating and

enabling factors of change, archetype theory's main focus is on interactions between actors within an organisation. Given the interdependency and interaction of the organisations and actors in the field under study, Fligstein's ideas of fields, power and social skill are integrated into the researcher's theoretical framework for analysing the dynamics of change because his ideas focus on interaction within the field and not just within an organisation.

It will be argued that whilst Bill 26 was the initial trigger of change, it was the co-operation and collaboration between key stakeholders that brought about a voluntary hospital merger the merging hospitals and a transition to a new coherent archetype. As will be shown, this process was enabled by the way in which the MOH chose to use its fundamental power as the ultimate source of funding for the hospitals. e reasons for this have more to do with the way the reform process was implemented at the local field level than with the imposed nature of the reforms as such, as similar policy reforms were imposed in both England and Ontario, with very different results.

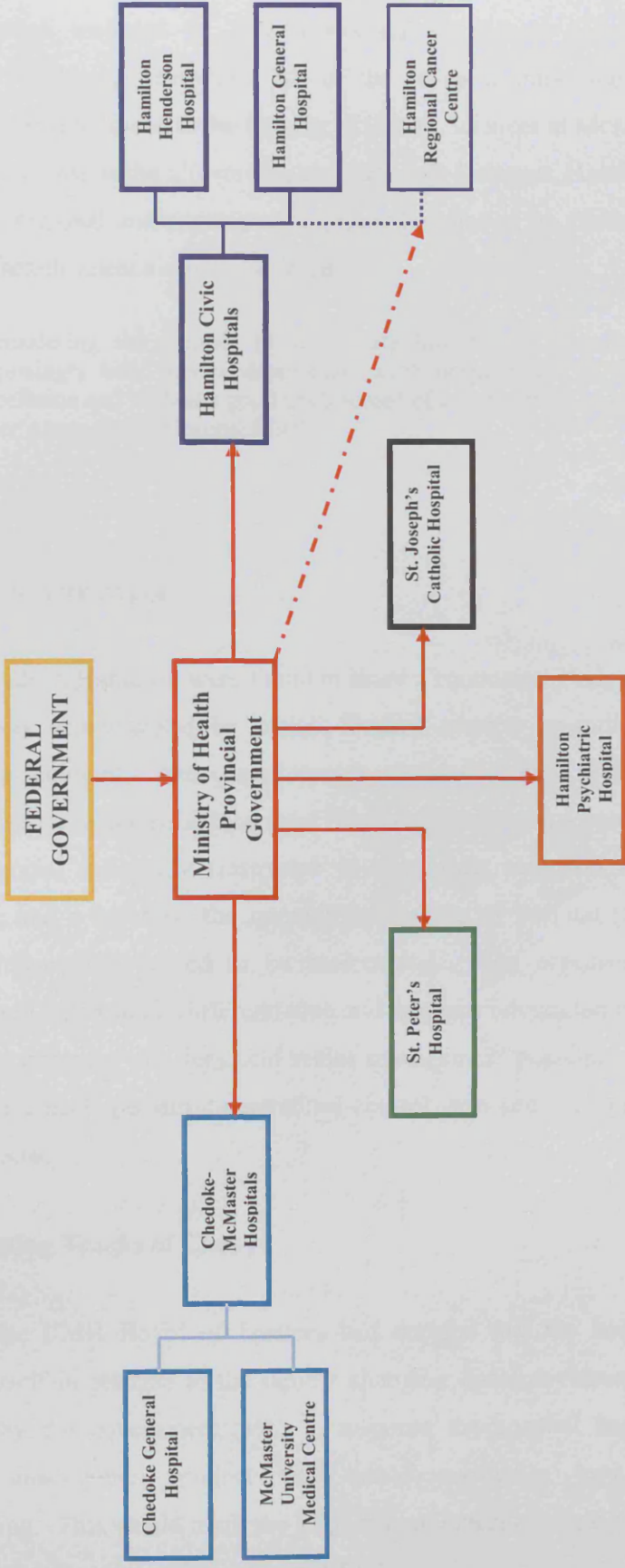
The study begins in 1996, when Bill 26 came into effect. The end marker for the case is October 1999, when the MOH initiated an Operational Review and Clinical Audit to determine reasons for the financial deficit of the new hospital.

## **6.2 The Organisational Field - Key Stakeholder Groups in Hamilton**

Hamilton had three acute care hospital organisations, Hamilton Civic Hospitals (HCH), Chedoke McMaster Hospital (CMH) and St. Joseph's Catholic Hospital (St. Joseph's). HCH operated two acute care hospital sites, the General Hospital in the industrial quarter of the city centre and the Henderson Hospital on the central mountain, which supported and shared accommodation with the new Hamilton Regional Cancer Centre. CMH operated the McMaster University Medical Center, an acute care hospital on the McMaster University campus in the west end of the city, and Chedoke General Hospital, a non-acute hospital on the west mountain. St. Joseph's was an acute care hospital the city centre, owned and operated by the Sisters of St. Joseph .

As can be seen from Figure 6.1, these hospitals were part of a larger hospital

Figure 6.1 Hamilton Hospitals Prior to the Merger - 1995



system, which included St. Peter's Hospital (a chronic care hospital), and the Hamilton Psychiatric Hospital. All of the seven hospital sites in Hamilton had teaching programs linked to the Faculty of Health Sciences at McMaster University or other departments at the University, and Mohawk College. Hamilton was home to a number of regional and provincial programs because of its status as one of the five academic health science centres in Ontario.

'Considering the number of acute care hospitals in Hamilton, there was surprisingly little service duplication. Each hospital had its own Centres of Excellence and we had a good track record of collaboration and sharing of each other's expertise.' (Hospital CEO)

### **6.3 Initial Archetypes**

The hospitals in Hamilton were found to share a common archetype. The interpretive scheme was characterised by patient-focused service (quantity and throughput); professional autonomy; and a local service provider identity. Systems, processes and practices were characterised by annual resource increments; a bottom-up management style; financial autonomy (restricted to non-profit activities and patient related practices); and a focus on the internal functioning of hospital (in-patient services); changes historically tended to be incremental. The organisation structure was characterised by medium differentiation and medium integration between clinical and managerial domains - doctors held senior management positions; a functional matrix based on medical speciality; centralised control; two-site management; and a single hospital focus.

### **6.4 Existing Tracks of Change**

In 1993 the CMH Board of Trustees had decided that the hospital needed to re-position itself in relation to the rapidly changing fiscal environment that was being imposed by the government [35]. In response the hospital launched an intensive strategic development project that would eventually lead to organisational restructuring. This would mark the beginning of extensive change to both the clinical programs and the service directions of CMH.

The hospital, which was based at McMaster University in the Faculty of Health Sciences, and the Medical School had achieved international success in the area of research and medical education but had remained significantly under-developed from a clinical service perspective and detached from many other community services.

‘McMaster Medical Centre was created by the University for the University. It was never thought of or used like a community hospital. It’s priorities were research and teaching and less about patient care.’ (Senior Hospital Executive)

‘The Civic was the people’s hospital. Friendly atmosphere, helpful staff and always managed with less. Mac was perceived as the ‘fat cat’. More money, lots of staff and arrogant.’ (Hospital Director)

‘Mac was about researchers, technicians and intellectuals. It was powerful but not user friendly.’ (Professor, Health Action Task Force)

The CMH Board recognised that the hospital must develop a stronger clinical and service role within the community if it were to survive the provincial restructuring process [27, 36]. The re-organisation of CMH was to be phased in over the next 3 to 5 years [27].

The Hamilton Civic Hospitals were also about to embark on a restructuring initiative at the same time. Even though the Henderson and the General hospitals had been amalgamated as long ago as 1962 the present organisational structure of the HCH did not provide for shared management, administrative or nursing responsibilities across hospital sites. Therefore the Board of Directors had decided to develop a new organisational structure that would bring the two hospital management teams together under one administration [1, 38b, 10, 20].

Thus, the hospitals in Hamilton were all, at the outset of the case, already undergoing some form of evolutionary change.

## **6.5 Institutional Upheaval: Accelerating Tracks of Change**

Under Bill 26, a new *independent* body, the Health Services Restructuring Commission (HSRC or Commission) was to be appointed to make decisions about hospital restructuring and to advise the Minister of Health on restructuring other parts of Ontario’s health services system [129]. The Commission was appointed for a term of four years from April 1996. The Commission had the power to make hospital

restructuring decisions without any need for ministerial approval [12]. The appointment of an independent body was seen by senior managers as a politically astute move:

‘...by establishing the restructuring commission what the government sought to do was *insulate itself politically from their own restructuring agenda....and the public actually bought into this.*’ (Hospital CEO)

‘So in terms of how hospitals were to be restructured which ones were merged, which ones were closed, which ones were left alone – *the ministry didn’t have any direct involvement in any of that.* Politically that was a smart move on the part of the government.’ (Hospital Vice President)

‘...the fact the government created a commission –the writing was on the wall. They were going to do something but the million dollar question was, what were they going to do to us and that was still a guessing game.’ (Senior Hospital Chief)

Here we see a clear similarity with the English case: government agencies trying to avoid being seen as directly responsible for the politically controversial restructuring decisions that would have to be made: although they have direct authority (to simply close a hospital or cut off its funding) they still need to induce co-operation in others and may seek to do this by getting people to believe that others are in control (Fligstein, 2001).

Many cities in Ontario were unable to reach consensus on cost reduction measures or ways to re-design their present health care services. In such cases, the Commission was left with no option but to enforce mandatory change initiatives through the use of its statutory powers [The Toronto Star Newspaper, July 7, 1996]. The Commission encouraged the District Health Councils (DHCs) and their communities to recommend service changes. This pre-emptive work made the Commission’s job easier as the Commission saw its role as working with the community to bring about change that was best suited to the needs of the local population [98]. The Commission recognised that local politics and professional biases would often impede this process at the local level and then it would be the role of the Commission and DHC to act as arbitrator to bring about the necessary change [22].

The Commission recognised that its task would be complex because it would be impossible to review hospitals in isolation from community and social services, or acute care in isolation from chronic and rehabilitative health services. Reconfiguring

the hospital sector had major economic and logistic implications. The Commission would need to take into account the quality of care, quality of management and administration, broader health systems issues, availability of capital and operating resources, and accessibility to health services in the community. Any recommendation to merge hospitals or reform community services would need to strategically address quality, cost and access concerns from a regional perspective [12].

### ***The Health Action Task Force***

In March 1995, the DHC and the MOH worked in partnership with community stakeholders to identify how Hamilton could improve and design a more efficient health care delivery system and to make recommendations on how this new system should be organised.

‘This was a really tall order. The first problem was that the MOH did not give us clear guidelines. Each region in the province had different directives but Hamilton wasn’t given a specific target, such as you must take x% out of the system. It was too open ended which meant open for interpretation.’ (CEO Community Organisation)

The first step was to appoint a 10-member Health Action Task Force (HATF or Task Force) to prepare a new health care plan for the region. The Task Force’s members all had professional experience as leaders in, or consultants to, public sector or community organisations. However, in relation to the Task Force’s work they were independent in that they had no direct association with or vested interest in any particular health care organisation. As a group, they would be powerful actors because their recommendations would influence the decisions of the MOH on the re-configuration of health care services in Hamilton.

‘...the task of forging *a new strategic direction* that would be *acceptable to all three* acute hospitals would be a real challenge. On the surface there appeared a willingness to share and collaborate with other hospitals but underneath they were all very territorial. This would not be an easy task for the Health Action Task Force.’ (Professor, Faculty of Health Sciences) (researcher’s emphasis)

Here the Task Force is addressing the problem faced by socially skilled actors of finding a way to join actors or groups with different preferences, and help reorder those preferences (Fligstein, 2001). Concepts of domain (what the hospitals should be doing) and appropriate principles of organising principles (how they should be doing



it) are evident in the quoted statement. The perceived aim appears to be to foster a common orientation across the acute hospitals, so as to in effect establish a coherent pattern of organisation (and thus an ideal template) for the restructured configuration of acute hospitals in Hamilton under the Bill 26 reforms.

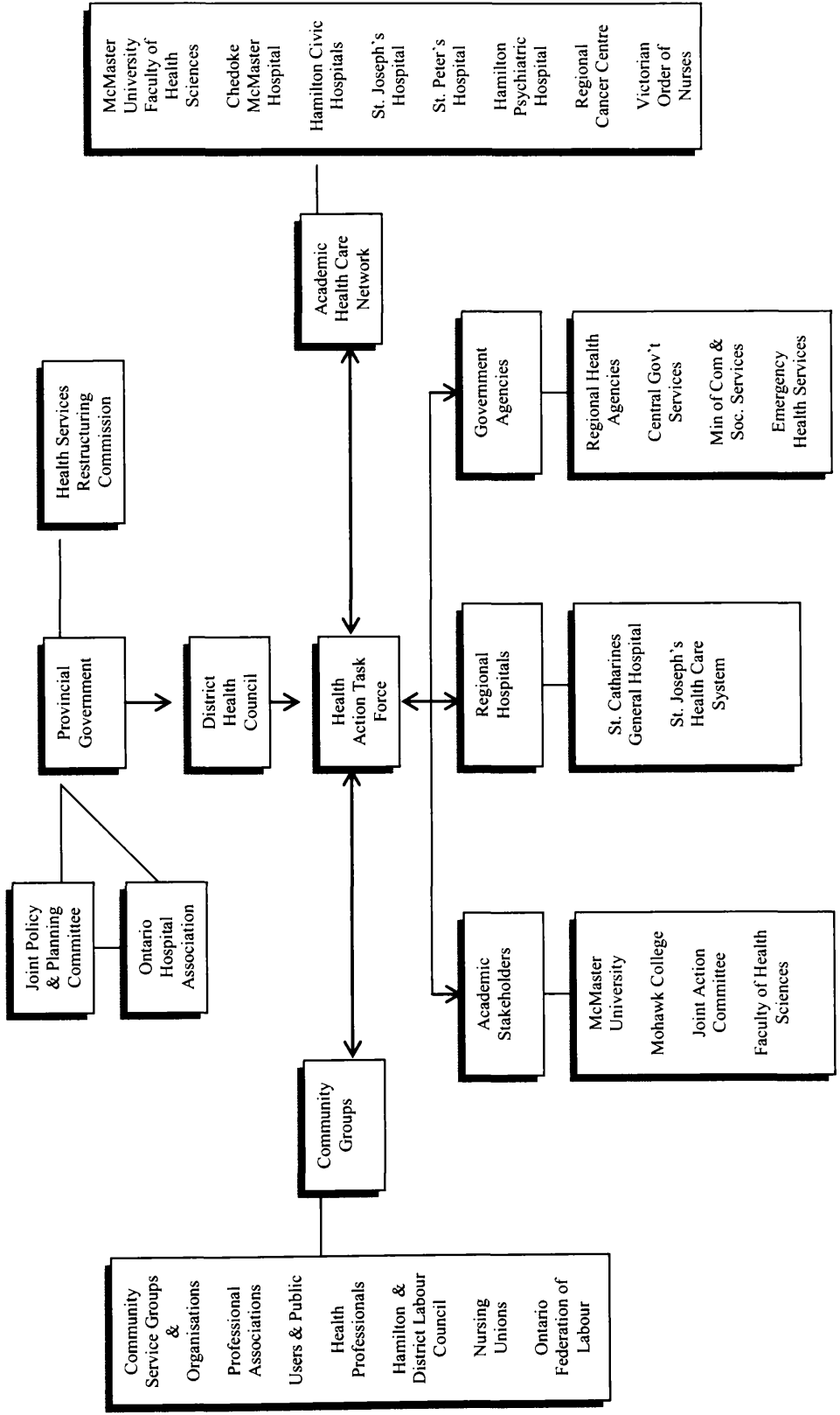
The various stakeholder groups who were involved in this restructuring process are identified in Figure 6.2.

The role of the Task Force was to develop a comprehensive health care plan for Hamilton that would strengthen and integrate the full range of health care services.

The Task Force anticipated that it would have two years to do this job, but discovered following the provincial general election on 8th June 1995 that the new government wanted to move more quickly, and that it would have to submit its report by Spring, 1996 [68]. Thus there would be an enforced stepping up of the existing evolutionary change within the hospitals to a revolutionary pace. Notwithstanding the drastic reduction of its timetable the Task Force used a comprehensive, consultative process to develop its plan and recommendations, involving feedback from a wide range of stakeholder groups in the community. The findings from these various sectors would be integrated into a series of recommendations designed to support a comprehensive plan. The process would involve several activities, many of which occurred concurrently, and all of which continued throughout the year [67, 69].

Individuals and organisations in the health care community were invited to submit reports, attend working sessions and focus groups or make formal presentations to working groups. In this way the Task Force would gain a clear idea of the prevailing purposive values and interests of these stakeholders, an essential factor if restructuring was to lead to a coherent pattern of organisation.

**Figure 6.2: Stakeholder Groups Involved in the Hamilton-Wentworth Health Services Consultation and Restructuring Process**



In all, more than 700 providers and community members were involved. The interim report prepared by the Task Force evaluated the strengths and weaknesses of the existing health programs and services, described any unmet needs or unresolved issues and recommended strategies that could be used to strengthen services, meet needs and resolve issues [67].

‘The Task Force left no stone unturned. We prepared inserts for the Hamilton Spectator and 186,000 copies were distributed throughout Hamilton. Several of our members spoke on call-in radio and television talk shows. And we also conducted 775 telephone surveys. I think we did a good job. We wanted the public to be informed and to be part of the process.’ (Professor, Health Action Task Force)

After this period of extensive information-gathering and public consultation, the Task Force began to shape a plan and develop a series of recommendations. The report would be published and feedback was invited before the final draft was submitted to the DHC and presented for a public vote. The outcome of the public vote would form the basis of the final report to be forwarded to the MOH [6].

The Task Force’s consultative approach is a good example of social skill: if the Task Force appeared open to stakeholders’ needs and not wedded to any predetermined course of action, stakeholders would find the situation more attractive for negotiation and be more willing to allow brokering or helping to forge a collective identity (Fligstein, 2001).

## **6.6 Actions taken by Key Stakeholders: Collaboration Agreement and Merger Talks**

The CEOs of HCH and St. Joseph’s came to the view that a collaboration agreement between the three acute hospitals would strengthen their collective position in relation to the Task Force’s review, but when CMH was approached it declined to participate in the proposed collaboration [9]. This was a political decision taken by the CEO of CMH. It was a public rejection, and was symptomatic of a long-standing rivalry

between CMH and HCH<sup>1</sup>.

‘trying to bring the CEOs of the Civic and McMaster together was like trying to mix oil and water. It just wasn’t going to happen. They both rubbed each other the wrong way. It was a stand off before it even happened.’ (Professor, Faculty of Health Sciences)

‘This alliance was important to the Civic. St. Joe’s had the Catholic Church, McMaster had the University and the Civic felt exposed. It needed this alliance more than the others.’ (Hospital Vice President)

The HCH Board was concerned that a financial deficit would weaken its strategic position in any government-directed merger with CMH [19, 20]. Merger negotiations would be influenced by political and financial power, and CMH was perceived to be in an advantageous position already through its closer affiliation, and sharing of premises, with McMaster University’s Faculty of Health Sciences. The Board decided to pursue the possible collaboration agreement with St. Joseph’s and the two hospitals agreed to conduct a study to analyse the impact of collaboration between them [9].

The collaboration agreement would not change the existing governance of either hospital. An Executive Management Council would be appointed and would have the overall management responsibility of the collaboration. This would include the implementation, monitoring, review and co-ordination of programs and services within the collaboration [9]. The HCH Board of Directors passed the initial motion supporting the collaboration with St. Joseph’s in Nov 1995. HCH and St. Joseph’s were initially hoping that their arrangement may have been sufficient to avoid any drastic compulsory restructuring of their organisations. The collaboration agreement was finalised on June 14, 1996.

This formal collaboration between HCH and St. Joseph’s was quite significant for several reasons.

‘Strategic alliances or collaborations isn’t something that is common place in healthcare. This was an innovative agreement and a real opportunity to cut expenses by sharing non-clinical costs.’ (Hospital Vice President)

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<sup>1</sup> Being a denominational hospital, St. Joseph’s was not involved in this local hospital rivalry.

‘Hospitals partnering to share services is the first step toward integrating our local healthcare community. This is our future.’ (CEO, Community Organisation)

‘The Catholic and provincial healthcare institutions have always operated independently of each other. This is a first for a business arrangement to have been forged between a denominational and non-denominational hospital in Ontario.’ (Hospital CEO)

‘Aside from saving costs in the long term – this arrangement is primarily intended to give both these parties *political advantage over McMaster*.’ (Hospital Vice President) (researcher’s emphasis)

The varying interpretations of the collaboration/strategic alliance are indicative, the researcher suggests, of the politically charged nature of the stakeholders' response to the reforms. Given the ‘very territorial’ (see above) character of each of the Hamilton hospitals and the motives of the HCH Board in pursuing the collaboration with St. Joseph’s, the collaboration agreement appears to be more about building a dominant political coalition than a concern for integrating the local health care community.

### ***Hospital Boards Initiate Merger Discussions***

The Ministry’s announcement also prompted the Boards of HCH and CMH to explore the opportunities for and benefits of merger of their organisations in order to further reduce costs and rationalise services. It had become clear to the Board of Trustees of both hospitals that their CEOs would not be able to work co-operatively, so they decided that the Board, and not the CEOs, would now make all key decisions.

‘Merger is a governance issue. Therefore it was right that the Boards would be the ones that would make the decision. They set the strategic direction and they have the power to make it happen. (Hospital Vice President)

‘...it made more sense to come up with our own solutions as opposed to having it imposed by someone from the outside.’ (Hospital CEO)

‘The government’s agenda was clear. Cut, slash and burn. So let’s start the process ourselves and try to be the masters of our own destiny.’ (Hospital Vice President)

‘The Boards had no choice. It was now war and the battle between the Civic and McMaster got nasty.’ (Professor, Faculty of Health Sciences)

The two Boards established a Transition Committee with authority to take the merger process forward. The Committee was expressly required to ensure equality of

participation by both hospitals in carrying out its work. The Committee received and considered a range of presentations and extensive information covering for example the financial positions of each hospital, their human resources and their medical staff structures. The Committee also consulted with the Faculty of Health Sciences, the Regional Cancer Centre and employee representatives [51, 63].

A merger would make this new organisation the second largest teaching hospital in Canada [48]. It was agreed that, until such time the merger was finalised, both hospitals would continue with their own restructuring/re-engineering initiatives. It was recognised that the two most influential and powerful actors in this change process would be McMaster University and the provincial government and that they needed to satisfy the demands of both these parties if their proposed merger and service re-organisation was to be supported. The University would be expecting the hospitals to collaborate with its teaching and research commitments while the MOH would expect the hospitals to strictly meet and adhere to their care priorities and fiscal budget restraints [147].

The proposed merger between CMH and HCH was a logical solution but it would not be without its problems. As potential partners, they were quite similar in relation to budgets, bed numbers, staffing complement, patient services and number of hospital sites. The real differences lay in their organisational cultures, style of management, and present budget deficits. CMH had a deficit of \$10.5m at the time of the proposed merger, while HCH was carrying a budget deficit of only \$1.5m (see Chapter 3, Table 3.1 on Comparative Hospital Statistics). The Boards of both hospitals acknowledged that they had been rivals competing for dwindling government funds in the past, but now they needed to look at other options if they were to survive the government's restructuring agenda.

During this initial period of merger negotiations, the University was not invited to participate in the merger discussions. However, when the Boards were unable to reach agreement, the University was invited to act as mediator to help resolve the issue:

‘We were finally invited to join the inner circle. People now saw us as the honest broker because we really had a vested interest in all sites.’ (Professor, Faculty of Health Sciences)

This comment is very much reflective of Fligstein’s (2001:114) perception of the social skill of ‘brokering’ rather than ‘blustering’: ‘skilled actors have to convince others that they are not narrowly self-interested and that others will gain personally from finding a negotiated position’.

It was important that the hospitals kept focused on completing this voluntary merger rather than risk mandated hospital closure by the Commission. During the merger discussions CMH was continuing with its own major re-engineering project, and HCH was continuing with its own re-organisation and in the process of finalising its collaboration agreement with St. Joseph’s. The new merged organisation would inherit the collaboration agreement and would continue to define shared programs and working practices between both hospitals [9].

The Transition Committee developed a merger framework, which mapped the merger timetable and key tasks over the next nine months. The first task was to recommend a structure and composition of a new Board [132]. It would also be the Board’s responsibility to outline a hiring process and find a new CEO [56].

The Transition Committee realised that integration of the two organisations depended upon identifying, early in the planning process, key actors and stakeholder groups who could lead on issues pertaining to medical staff, finance and human resources. These stakeholders had both expertise and internal information that was vital in identifying potential problems during the transition period and in understanding how each organisation would perceive and react to the proposed merger. Mergers are complex and these issues needed to be addressed early in the merger process especially where the merger spans several hospital sites [Connections, Feb 96].

### ***The Medical Staff Embrace the Merger***

The medical staff were already organised through a Medical Advisory Committee in each of the two hospitals. The hospital’s Chiefs of Staff joined forces and quickly prepared reports comparing the clinical departments and structures across the hospital

sites, highlighting issues they considered would need addressing during the merger [56]. These issues addressed both medical staffing concerns and potential clinical service problems. Both the HCH and CMH medical groups recognised the potential advantage of the merger. The Medical Advisory Committees joined to draft medical by-laws for the new hospital [57, 58, 59]. As a group, the doctors were the first stakeholders to work collectively to support the merger, raising issues concerning practice and professional interests, and submitted medical by-laws to the Boards before the two hospitals were officially merged [61]. This collective action by the medical communities across both hospitals would give the doctors some political power and profile within the new organisation.

‘It was a smart move for the doctors to get together from both hospitals. It allowed us to thrash out our differences behind closed doors and present a united front to the Board. It was actually very productive and politically it was a good move. We felt strongly that we needed to *protect our clinical practice and specialities*.’ (Medical Director)

‘The doctors lead the way, as they were the first group to really embrace the change. They gave the merger momentum and it helped pave the way for other staff.’ (Hospital Vice President)

These by-laws can be seen as a major contribution to the interpretive scheme for the merged hospital organisation, as they would inform ‘beliefs and values about appropriate principles of organising’ (Greenwood and Hinings, 1988:295).

## **6.7 Values and Interests Articulated Again**

The Task Force presented its first report to the Hamilton DHC and to the community on the 4<sup>th</sup> March 1996. The main body of the report ran to 89 pages. The report’s five-part strategy examined specific needs and service reconfigurations in the areas of primary care, continuing care, mental health, acute care services and education and research [6].

The Task Force acknowledged, and expressed support for, the efforts made in recent months by various health organisations in the community to collaborate in governance and in service delivery, including the collaboration agreement between St. Joseph’s Hospital and HCH and the proposed merger of HCH and CMH. However, the Task Force found further opportunities for efficiencies in admission management,



discharge/transfer management and length of stay management, and formulated new targets [67].

### ***Task Force Recommendations***

The Task Force's main recommendations concerning acute care services were as follows. St. Joseph's would be closed, and its programs and services would be moved to the Henderson Hospital site. The Sisters of St. Joseph would take over the governance of the Henderson site. The existing Hamilton Psychiatric Hospital site would also be closed, and the hospital re-located to become an addition to the Chedoke hospital site. Thus the number of acute hospital sites would be reduced from four to three, and the total number of hospital sites would be reduced from seven to five. The report noted that this recommended configuration of acute hospital programs and services, which kept an acute hospital on the university campus, was designed to acknowledge the value of an excellence in service, education and research, and to provide the critical mass to support strong academic programs [67].

The Task Force report also targeted HCH's Henderson site for partial closure with the recommendation that several acute services should be re-located to CMH's McMaster site [67]. The Henderson site was location-sensitive for the local mountain community and for the Regional Cancer Centre was located on the site. The criteria used to site programs and services can be referred to in Figure 6.3.

**Figure 6.3: Criteria Used for Distributing Programs across the System**

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**Criteria used by the Health Action Task Force to Site Programs and Services**

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- critical mass requirements
  
  - co-dependencies and complementarities among programs
  
  - the sites' physical capacity
  
  - program cultures
  
  - impact on flagship programs
  
  - operating room requirements
  
  - supporting teaching and research requirements
- 

Source: Our Health, Our Future: Comprehensive Health Care Plan for Hamilton-Wentworth. The Health Action Task Forcer Report, 4 March 1996, pg.72.

The ramifications of this recommendation were grossly underestimated.

'It was a really bold move by the Task Force to announce hospital closures and to close St Joe's which is near and dear to the hearts of so many Hamiltonians. Wow...did this send shock waves across the City. And boy did people sit up and take notice then.' (Trade Union Representative)

'I don't know whether the Task Force was naive or was having delusions of grandeur to think for one minute they could take on the Catholic Church. They had already closed two Catholic hospitals, one in Brantford and the other in Guelph and there was no way they would allow this hospital to close and you have to realise this was their flagship hospital as well.' (Hospital Board Member)

'When the Task Force recommended that St. Joe's close, they never saw the Catholic backlash coming. The Bishop got involved, he rallied the priests and the parishioners and the battle began between the Catholics and non-Catholics in the community. The message was loud and clear – hands off St. Joe's.' (Professor, Health Care Task Force)

## *Stakeholders Challenge the Task Force's Report*

Between 4 March and April 15 1996 the Task Force received 1,470 calls, 272 faxes, 1,334 letters, 46,578 mail-in cards, 84,668 signatures on petitions against moving St. Joseph's and 606 other formal submissions. There was widespread community support for an integrated health care system and for several of the recommendations in specific areas, such as developing more capacity in long-term and chronic care. However, the proposals for reconfiguring the acute care system provoked the strong opposition from the community, which expressed concerns about (i) the proposed reduction of acute care hospitals from four to three, (ii) the suggested distribution of acute care programs and services among three sites, and (iii) the methodology used and the interpretation of the data analysis. A number of submissions expressed concern about the need for an implementation plan, the importance of staging changes in the system appropriately, and the need to reinvest any savings in other parts of the health system [69].

The City Council disagreed outright with the Task Force recommendation to close an acute site and passed a motion to support four acute care hospitals; it was concerned about the economic implications of such restructuring initiatives and how these proposed changes would effect local transportation systems in relation to service access. The local community became embroiled in politics and Task Force members came under tremendous pressure.

'It was a scary time. This was an emotive issue and when I arrived at one of the public forums my car my surrounded by pickets, people shouting and pushing the car.' (Chair, Health Action Task Force)

'The Chair of the Task Force received death threats, his house was defaced, it was unbelievable. The Task Force members were under terrible pressure.' (Professor, Health Action Task Force)

'So there was a lot of dirty stuff going on. But no-one has ever really admitted that and you know the Task Force people were just trying to be good citizens. You have to give them credit because they didn't want to drag out all the dirt but they took an awful lot of heat.' (Hospital Vice President)

The Academic Health Care Network (AHCN) submitted a detailed response to the Task Force on 12 April 1996. The members of the AHCN were HCH, CMH, St. Joseph's, Hamilton Psychiatric Hospital, St. Peter's Hospital, the Hamilton Regional

Cancer Centre, the Victorian Order of Nurses and the Faculty of Health Sciences of McMaster University [50]. The AHCN was thus a powerful coalition of key stakeholders. The AHCN's response, although largely supportive of many aspects of the Task Force report, proposed that St. Joseph's be maintained as a full acute care site, and the Henderson hospital be reduced to a cancer hospital with a small number of non-oncological beds and a 24-hour urgent care centre. The AHCN proposal argued that future demands for acute care beds would exceed the capacity of three acute care sites and that a fourth site should be retained for acute care to ensure that the hospital system retained the flexibility to meet the future needs of the population [69].

'We weren't convinced that closing a hospital really addressed the future needs of this growing community, especially on the Mountain. It would be staggering to contemplate the expense of having to build another hospital in the not to distant future.' (General Practitioner)

The University expressed concern about the potential disruption of research centres with the moving of hospital sites and hospital programs and services. The Task Force had not addressed the impact of the changes on research and education, leaving this to be addressed in the implementation stage [69].

### ***Task Force's Final Report***

After all the submissions received from the community were carefully analysed, the Task Force prepared a second report, which it called the 'Implications Report', addressing the concerns raised by the community. The Task Force observed that it was pleased that so many of the key participants in the system came together to work on the issues highlighted in its report [69].

In its Implications Report the Task Force modified some of its recommendations, to accommodate concerns raised by the community, but did not significantly change its recommendations with regard to the reconfiguration of acute care services. The Implications Report addressed in detail the AHCN's proposed alternative configuration of acute care services.

The Task Force's final submission, comprising its Report of 4 March 1996 and

Implications Report of 13 May 1996 and executive summary, was presented to the Hamilton DHC on 13 May 1996 [67, 69]. All stakeholders were given a copy. The DHC would vote on the recommendations at a meeting later the same month to which the public would be invited.

## **6.8 Key Turning Point: Hamilton DHC Bows to Community Pressure**

The DHC contacted every CEO and Board Chair of the hospitals and all the major community agencies in order to determine whether they would support the Task Force recommendations. Members of the DHC were under political, professional and emotional pressure to make the right choice.

‘We met with every CEO and Board Chair of the hospitals and all the major community agencies to find out where they stood, what they were thinking and how they felt the community would handle the outcome with so much infighting.’ (Hospital Vice President)

The number attending the DHC’s public meeting far exceeded the DHC’s expectation, and the meeting had to be re-convened at the Hamilton Convention Centre with over 800 in attendance. The political backlash to the proposed closure of St. Joseph’s became more apparent as the meeting progressed.

‘We had no idea there would be such a turn out. We had booked a room for 100 not 800. The public was enraged, there were demonstrations, DHC members were intimidated to the point where some felt they could not vote and the meeting was a nightmare.’ (CEO, Community Organisation)

This was a highly dramatic expression of the beliefs and values of the wider local community. In the end, the DHC voted against the proposed hospital closures and in favour of maintaining four acute sites, three of which would be full acute hospitals, with 4 full emergency rooms. The only hospital site to close would be the Hamilton Psychiatric Hospital. The DHC’S final report was forwarded to the MOH on May 29, 1996 [68]. It would then be reviewed by the Commission.

## **6.9 Hamilton Civic and Chedoke McMaster Hospitals Merge**

In June 1996 the joint HCH and CMH merger Transition Committee submitted its report on the proposed merger to the hospital Boards, recommending that the Boards

proceed with the merger. The Committee concluded that the hospitals faced a number of common challenges and would be better placed to address them as a single organisational entity, and that benefits could be derived from critical mass, economies of scale, medical staff integration, enhanced relationships with the medical school, streamlined management and support services and inter-site integration and collaboration [51]. This constituted a fairly comprehensive set of principles of organising that would form part of the new interpretive scheme. In considering the merits of the proposed merger the Transition Committee took a number of factors into consideration (see Figure 6.4). It found that the proposed merger was supported by many community stakeholders, who believed there was a strong case for merger.

‘...people were prepared to make some hard decisions and shifts when they can see the end point.’ (Professor, Member of the Health Action Task Force)

‘Hopefully the merger will side step closure but it’s the Commission we need to worry about. Take a look at their track record – it’s not too promising.’ (Local Union President)

‘Restructuring ourselves was the only way we were going to beat the system.’ (Hospital Clinical Manager)

The Transition Committee had sought wide-ranging input into the selection of a name for the new legal entity and enlisted the help of focus groups to draw up a short list. The Committee decided to recommend the name ‘Hamilton Health Sciences Corporation’, noting that it expected that the individual hospitals/sites would continue to be known by their existing names [63].

‘I think calling it the ‘corporation’ was the wrong thing to do because it implied business and business implies bottom line not patient care and I think that turned off a lot of people.’ (Hospital Director)

‘They really tried to convince the public that this was a great new name – banners, bill boards, promotional material. Forget it, the Henderson would always be referred to as the Henderson and nothing else.’ (Hospital Program Director)

The Committee recommended that the search for a new CEO should be an open process [147]. The CEO of HCH applied for the position, unsuccessfully, and at the last minute the CEO of CMH resigned and left the organisation before the merger was finalised. The resignation of the CEO of CMH caused considerable political fallout and bad feelings both within the organisation and among various community

**Figure 6.4: Case for Merger**

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**Factors Taken into Consideration**

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**Facilitate continuous improvement of the quality of patient care**

- consolidating clinical programs and enhancing the efficiency and effectiveness of care delivery systems
  - developing of an integrated delivery system enhancing the continuity of care
  - improving patient access
  - developing uniform clinical guidelines and care maps
  - attracting clinical recruits
- 

**Enhance education and research**

- better co-ordination and integration of activities with the University
  - developing specialisation and research reputation
  - attract research expertise and funding
- 

**Enhance the leadership position in the health system**

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**Simplify decision-making and improve relationship with other stakeholders**

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**Strengthen the ability to deal with current fiscal pressures:**

- economies of scale - combining administration and management producing-savings from the elimination of duplication, streamlining and standardising internal processes and the integration of systems
  - easier implementation of support services
  - a larger and more powerful purchasing base for a wide-range of products and services. (more attractive agreements and contracts with suppliers).
  - estimated operating cost savings in excess of \$9 million per year.
- 

Source: Chedoke-McMaster and Hamilton Civic Hospitals Proposed Merger, Report of the Transition Committee. June 1996, pp. 9-11.

stakeholders.

‘What kind of message does it give the staff when the leader abandons them before the change process and key decisions are made. Some of the folks that worked with her were saying that they felt betrayed.’ (Hospital Director)

‘The CEO actually left before the merger and so they felt a little bit abandoned. I think they didn’t have the same preparation. They weren’t a team in fact they were anything but a team and it had some impact on our team functioning as the new group but you could see the difference in fact some of the people previously at McMaster say you know we were really a little bit jealous at the cohesiveness of your group so I believe strongly that the preparation for merger makes a difference.’ (Hospital Vice President)

The Boards of HCH and CMH accepted the Committee’s recommendations and accompanying draft by-laws and other legal documentation. The approved resolution to amalgamate CMH and HCH and completed legal papers were sent to the MOH in July 1996 for approval, with a proposed effective date for the merger of 1 October 1996 [63, 56]. The MOH approved the merger as proposed.

As is clear from the above account of events, the process of negotiating and agreeing comprehensive merger terms was completed in a matter of months. The Commission had yet to turn its attention to Hamilton and it was possible that it would require further re-structuring; however in the meantime the process of implementing the merger terms would begin.

### **6.10 The Post-Merger Phase: The Restructuring Process Begins**

The first two staff appointments to be made in the new hospital were the external appointment of the CEO and the internal appointment of the Chief of Staff [21, 131].

‘I think for me it even confirms more when appointing a new CEO in a merged organisation you can begin to understand how problematic it would be bringing in one of the existing CEOs no matter what decision they make it would always be seen as biased.’ (Professor, Faculty of Health Sciences)

The new Board of Trustees, the joint Medical Advisory Committee and the CEO were now in place and ready to take the hospital forward through a series of restructuring stages [63]. The new hospital was thus developing the capacity for action necessary to manage the transition from one template of organising to another (Greenwood and Hinings, 1996).



The organisational restructuring process was envisioned to take place over the next five years [52]. The following goals were identified as priorities for the first 6 months. First, an interim senior management team would be appointed. This would be crucial for developing a new organisational structure [109]. Secondly, the CEO would begin to set the strategic direction of the new corporation. This would involve the introduction of a new approach to the strategic planning process and the development of the preliminary mission, vision and , value statements for the organisation [55, 21]. The third set of tasks involved establishing the building blocks necessary to facilitate the integration of programs and services [116, 117]. These included the development of processes and structures in such areas as human resources, communication strategies both internal and external and the logistics of information transfer across sites [109, 113]. While the final set of tasks focused on developing specific integration plans for the clinical programs, specialist services and support departments. The process of integrating programs and services had to take into account issues in the wider context, including the restructuring agenda, the program re-design initiatives and resource management [109]. All of these activities and changes were in preparation for the Commission's review [63]. This would be a major hurdle for the Corporation because the Commission still had the power to challenge and reject any of the changes

### ***Senior Management Team***

The hospital management would now be responsible for four sites. The size of the hospital had doubled and a management presence to support staff at each campus would be a key consideration in the organisational design . (Refer to Table 3.1 in Chapter 3)

The selection of the senior management team would be a two-stage process. The transitional team was established at the onset of the new organisation in September 1996 with 11 Vice Presidents selected from an existing group of 23 senior executives [71]. The transitional management team would be in place for 18 to 24 months. The appointments were split between the two hospitals' management groups. Each senior VP would be responsible for activity on all four sites.

The new CEO chose a transitional management structure similar to that used by the two hospitals so as to minimise disruption to these ongoing processes [106, 107]. The transitional management team would be responsible for overseeing the organisational restructuring and program integration phase of the merger before any further downsizing of the senior executive group and reduction of the number of clinical programs [71]. The transitional management structure can be seen in Figure 6.5.

The transitional management team was downsized again in 1999 leaving 8 Vice Presidents to take the organisation through the restructuring process [71]. Each time the senior team was downsized their respective organisational portfolios and span of control would increase. Figure 6.6 shows the configuration of the final management structure.

### ***Setting a New Strategic Direction***

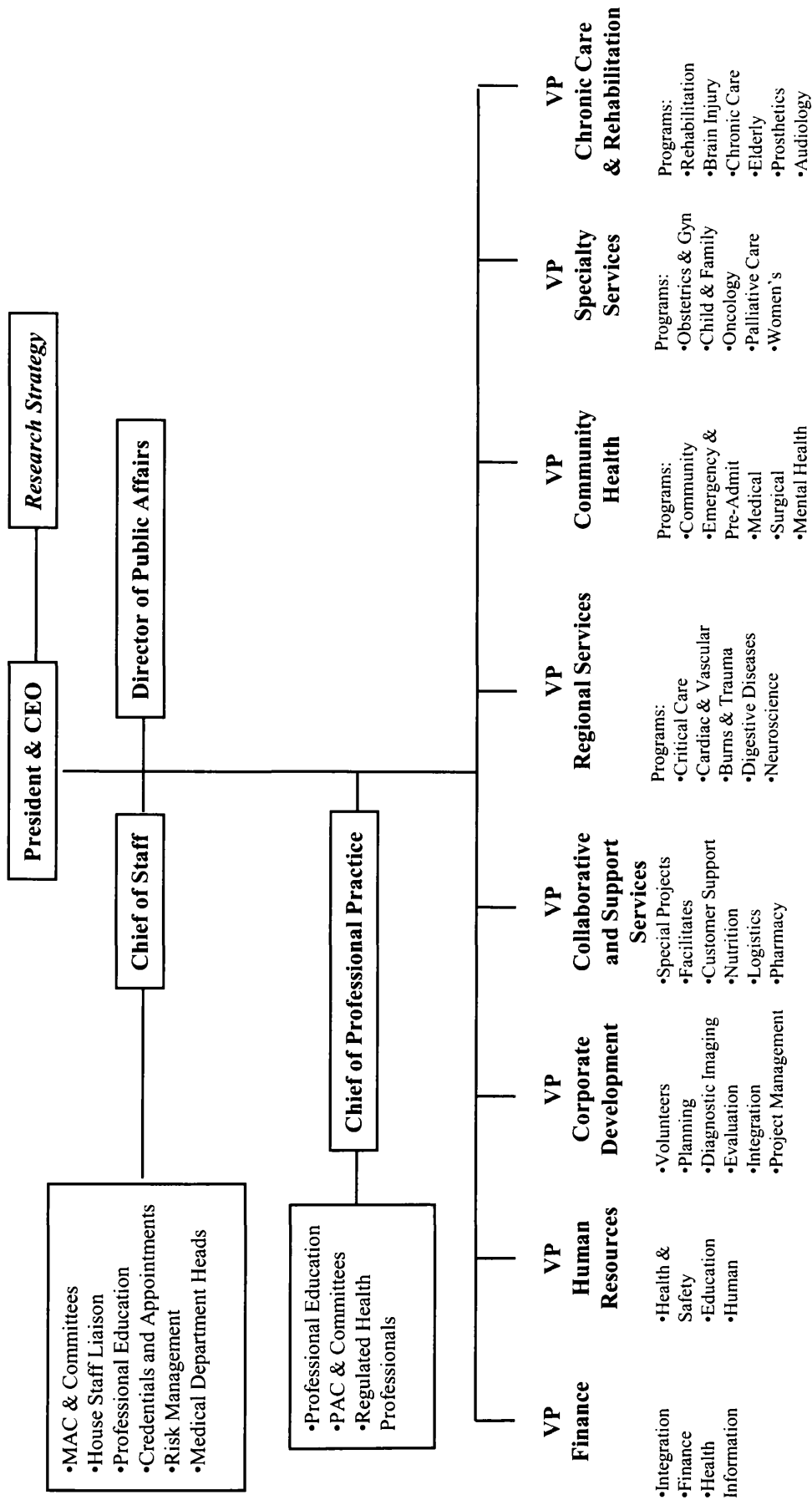
Although both hospitals had supported a management style which encouraged and championed participation from the bottom up, this was not to be the management style in the new organisation. The new CEO described his role as that of a strategist, setting the organisation's direction with the support of the Board. The CEO stated that the merger was about optimising resources and enhancing quality [95a]. The main challenge surrounding this merger was that it was occurring at a time of shrinking revenue. The CEO wrote in document stating that mergers were about:

‘leveraging synergies between organisations and making the most out of the collective resources’ [55].

The CEO would have to be decisive and directive in the current climate of rapid change, and expeditious in his approach to strategic planning because the luxury of long term planning was gone [89]. Many of the issues which needed to be taken into consideration had already been flagged by the Commission, such as reducing length of stay targets.

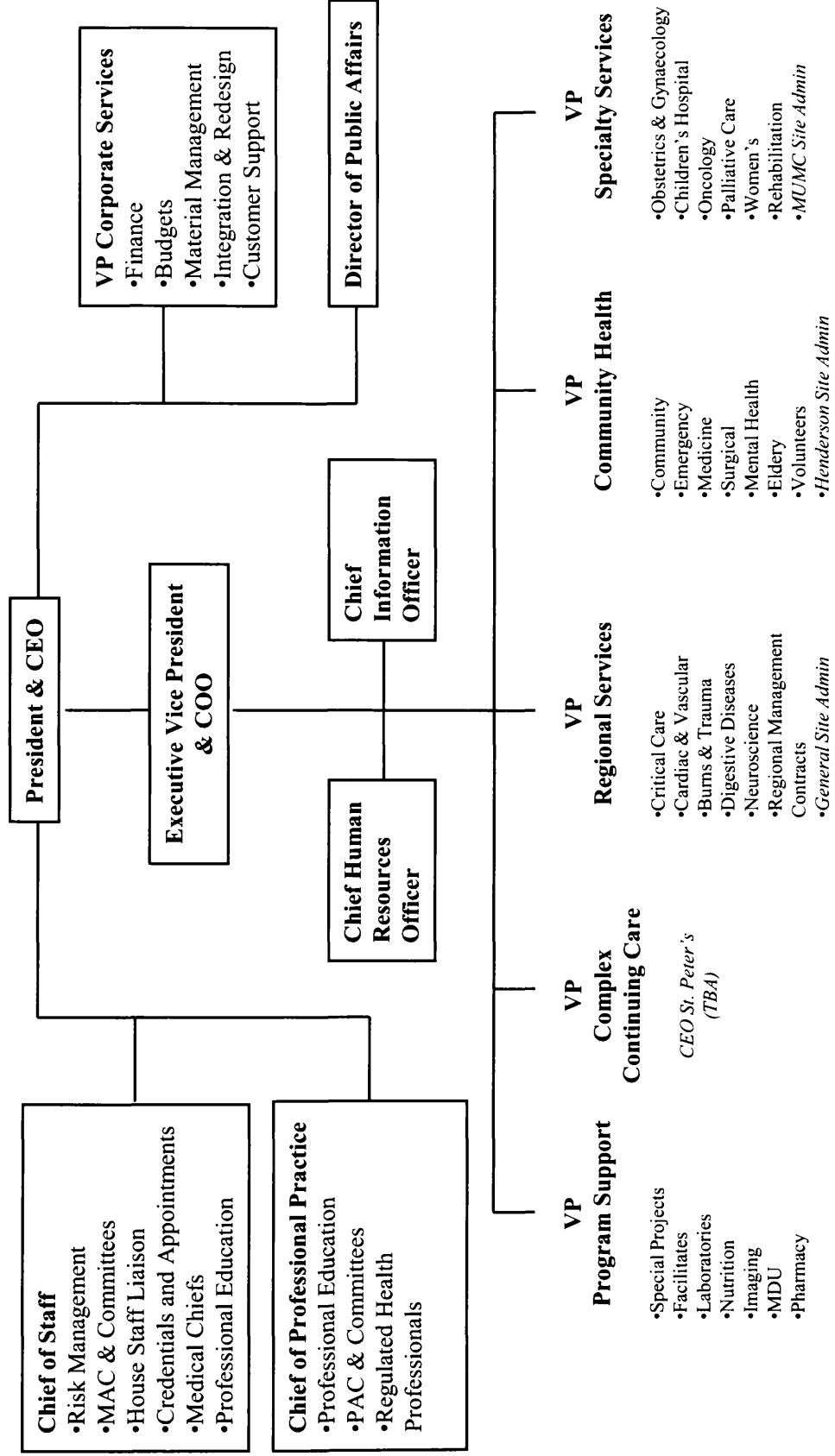
The reconfiguring process could not be finalised until the Commission had delivered

**Figure 6.5: Hamilton Health Sciences Corporation – Transitional Management Structure, 1996**



Source: Hamilton Health Sciences Corporation, Fiscal Report for 1997-98, Amended Operating Plan, August 1997

**Figure 6.6: Hamilton Health Sciences Corporation – Final Management Structure, February 1999**



Source: Hamilton Health Sciences Corporation, Staff Orientation Package, Human Resources Department, 1997

its final edict and it would be this balancing act that would be the real test for the new hospital's leadership. In this period of limbo the leadership would have to bring about the changes required to move the merger forward and still deliver quality patient care, while at the same time trying to second guess what changes the Commission would recommend. The hospital's new CEO stated:

'...in terms of strategic planning, we were essentially just trying to tread water to survive the restructuring. Trying to plan for the future was difficult because we were about to move into a era of provincially mandated restructuring, whereby the restructuring commission could decide what programs we ran to what buildings we used. They had the power to dictate our future and make all the decisions for us.'

### ***Defining and Supporting the Core Business and Mission of the Corporation***

The CEO decided that an inclusive and consultative approach to planning should be used in this environment of rapid continuous change. The strategy document was presented to 14 different focus groups [75]. Their feedback played a major part in re-shaping the Corporation's strategy. This focus group approach was found to be extremely successful and had been used twice during the transition management phase. It provided a fair amount of information from a variety of highly respected community leaders who had a wide breadth of experience and expertise in the field of health care. Their feedback was constructive and relevant for an organisation and community undergoing transition.

'I have actually found that focus group activity significantly informs what our strategy is and it ensures better alignment between strategy and community need.' (New Hospital CEO)

During the strategic planning process the first task for the new senior management team was to develop a *new mission and value statement* [84]. The core business and missions of the Corporation would include community hospital services, regional referral services, highly specialised services and chronic care and rehabilitation [102]. As a teaching hospital, education and research were also major components of the mission. The hospital *structure would need to reflect the organisation's mission* and assure leadership accountability for each core component of the organisation's mission [73]. Thus the new hospital (Corporation) is formulating its own new archetype: mission and values are to be reflected in the hospital's structure and

systems. Here we see an example of an archetype not derived from an existing template in the institutional sphere, but one created by the organisation itself from a newly defined set of mission and values.

In order to make the transition to the new archetype, however, the new hospital would need to have sufficient *understanding* of the new conceptual destination, the *skills and competencies* required to function in that new destination, and the *ability to manage* the process of getting there. Having all of these constitutes capacity for action (Greenwood and Hinings, 1996). The first of these was found to present no difficulty:

‘Defining the hospital’s mission and creating the vision statement wasn’t so bad. We were lucky because both hospitals had relatively similar value statements. So we were able to bring these together and merge them. We were more or less on the same page already.’ (New Hospital Executive Vice President)

‘Getting consensus about the vision statement was really important in the early stages because everyone needed to agree where we were going and what was expected of them. After I arrived it was clear to me that we were going to need to put some key statements in place and so we developed pretty early on a statement of mission, vision and values which then led to a management retreat.’ (New Hospital CEO)

‘As mergers go, it is my true belief that the merger between Chedoke McMaster and the Hamilton Civics is as easy as a merger of this size and complexity can get. There was good alignment really between the two organisations overall.’ (Hospital Vice President)

### ***Processes and Structure: Testing Capacity for Action***

It was decided that the new structure would be relatively flat, with a preference for fewer rather than more reporting levels [71, 95a, 98]. The senior executive level of the organisation would be substantially leaner with one whole senior level of administration removed.

The next level of management to be put in place would be the program/department directors [94]. Determining the optimal structure design at the program level would be challenging because of the complexity of multi-site locations. The planning process would need to include broad consultation and collaboration with both internal staff and external stakeholders [106, 98]. This would be the joint responsibility of the

Vice Presidents, program directors, key medical staff and a newly created Office of Integration.

While their values were similar, the merging organisation had different structures. CMH had a decentralised program management structure while HCH was developing a more modified approach [17, 34]. The new HHSC would now result in 19 clinical programs across four clinical portfolios [78]. The spread and scope of this new program structure can be seen in Figure 6.7 and gave rise to problems of manageability, testing the new hospital's capacity for action:

‘Questions are being raised about how many programs there are and how they should be organised. We will look then at what resources are allocated to it, what kind of administrative support is available, how many clinical managers are there reporting to program directors and how much management is at the front line level. The sense I’m getting here is there isn’t enough and that the downsizing in the management structure has been too severe.’ (Hospital Executive Vice President)

‘19 clinical programs is too many. It was far too ambitious to structure, let alone assign staff. Moving staff across sites had become a labour relations nightmare.’ (Senior Hospital Director)

‘Program management can be a good way of delivering patient care if all parties are committed to making it work but it takes a lot of work, communication, team building resources and time.’ (Hospital Clinical Manager)

‘We had way too many programs. Really it was unmanageable but the problem was that we were just following orders and we thought we were being equitable and fair but no one at that time had enough history to critique the process. This was a new experience for all of us sitting around the table.’ (Hospital Vice President)

**Figure 6.7: Hamilton Health Sciences Corporation Clinical Programs, 1997**

<b>CLINICAL PORTFOLIOS</b>	<b>PROGRAMS</b>
<b>Community Health</b>	Community Services Emergency and Pre-hospital Medical Surgical Mental Health
<b>Regional Services</b>	Critical Care Cardiac and Vascular Burns, Musculoskeletal and Trauma Digestive Diseases Neurosciences
<b>Special Services</b>	Obstetrics and Gynaecology Women's Health Acute Children's Services Child and Family Centre
<b>Chronic Care and Rehabilitation</b>	Rehabilitation Acquired Brain Injury Health Services for the Elderly Chronic Care
<b>Support Service Portfolios</b>	Finance Human Resources Corporate Development Support Services

Source: Hamilton Health Sciences Corporation Operating Plan for the Fiscal Year 1997-1998. Published August 1997.



The Clinical Programs task force co-ordinated all efforts across programs. Sub-groups were established to set out guiding principles and directions. Each group was responsible for defining the clinical programs and the program organisational structure, designing patient care delivery models specific to that particular program and developing templates for resource management [107]. This approach ensured consistency and management standards across the different clinical programs.

The HR system and policies in each hospital were very different and the systems could not communicate with each other. Designing a compatible IT system would become an on-going project for the next 3 years [83]. Labour relation issues were also a major problem. The two HCH hospitals and Chedoke Hospital were unionised, but McMaster had never been unionised. This created tremendous tension between the hospitals.

### ***Managing Organisational Transition and Integration***

The integration process was be overseen by several different task forces. Each task force was accountable to a member of the senior management team, who would be responsible for that specific portfolio. The task forces had clearly defined goals, objectives and target dates, and membership was open to hospital staff and medical/professional staff. Members were included from each hospital site [107]. This approach was in line with Greenwood and Hinings' (1996) argument that capacity for action embraces both the *availability* of the necessary skills and their *mobilisation*. The seven task forces appointed covered the following areas: human resources, transition management (staff support), information and decision support systems, professional staff organisation, research and education, clinical services and programs and support services and other departments [107, 139, 113]. This use of staff expertise was an effective approach, as it both reflected and developed an internal commitment to change and assisted the staff in understanding and confronting resistance to program changes. Such commitment greatly assisted the new hospital's ability to manage the transition and is thus an enabling dynamic of change (Greenwood and Hinings, 1996).

The redesign project team was responsible for working with the clinical portfolio staff and defining, implementing and evaluating the strategies for the redesign initiatives [80]. Its main role was to try and influence the change process at the program level, but there were many problems that impeded their progress and threatened to undermine the whole process.

‘Many of the frontline staff felt the pressure to change was driven by the senior management with little input from the front line staff. The timeframe was too quick. It was unrealistic. Everyone was feeling overloaded. Units were closing, programs were moving, staff were being bumped. It was a crazy time and stressful for everyone.’ (Hospital Staff Nurse)

In addition to its internal restructuring agenda the new Corporation needed to be responsive to external pressure coming from the impending review by the Commission and on-going collaborative projects with St. Joseph’s and other health care providers [107, 115].

### **6.11 The Health Services Restructuring Commission Evaluates the Hospital Merger and Service Re-configuration Changes**

In April 1997, the Commission began its work in Hamilton. Its first task was to study the DHC’s health care restructuring recommendations for the City and to review any other written submissions from interested organisations or individuals [67, 119]. Thus, once again, stakeholders would be invited to articulate their beliefs and values.

The Corporation submitted a report to the Commission to provide it with a more complete understanding of the Corporation as a newly merged health care organisation as well as to offer comment on issues relevant to the work of the Commission [81].

#### ***The Corporation and the Academic Health Care Network: a United Front***

The Corporation’s report submitted to the Commission described the progress made since the merger between CMH and HCH and expressed its support for the recommendations made by the DHC to the MOH [87, 88, 120, 121]. The Corporation acknowledged the need for restructuring as a response to fiscal constraints imposed by

the government, but emphasised the collaborative response and voluntary restructuring already initiated in Hamilton as a local solution [81].

The merger of CMH and HCH provided evidence of Hamilton's commitment to responsible health services restructuring. The Corporation had demonstrated its commitment to enhancing value by consolidation programs to increase clinical excellence, facilitated by unified governance and management. It was supporting community partnerships through the agreement with St. Joseph's Hospital, on a number of collaborative projects, aimed at rationalising services and decreasing costs [81]. The Corporation's programs and services were distributed across four campuses and they provided primary, secondary and tertiary care for both the population of Hamilton and the region. The AHCN's report corroborated the submissions made by the Corporation [105].

### ***The Commission Issues its First Report***

The Commission conducted site visits in Hamilton in June 1997 and its members met with residents, administrators, board members, physicians, professionals, labour representatives and others in an effort to better understand the issues affecting and interrelationships among the hospitals and other health services in the region [87]. The Commission's initial report was issued in November 1997 and the health care community was given 30 days in which to respond to the report. The Corporation requested and was granted an extension, and were given a final deadline of January 18, 1998 [88, 89].

The Health Services Restructuring Report supported many of the proposals put forward by the DHC. It proposed that the Corporation and St Joseph's should function as two separate hospitals and agreed to keep the Henderson as a full service acute facility specialising in oncology and an emergency department [87]. The health care community was disappointed however with the Commission's proposal that St. Peter's Hospital and the Chedoke hospital site would cease to operate as hospitals, which would severely affect the rehabilitation and chronic care roles of both. [90].

The initial reactions of most stakeholders to the report were positive, and they felt they could work with the recommendations put forward by the Commission [88]. It would now be the responsibility of the hospital boards and other community stakeholders to respond to the report.

‘Actually we came out of the restructuring process completely unscathed compared to other hospitals in the province – we still have all our sites.’  
(Surgeon)

### ***Stakeholders Respond***

The health care community was hoping to respond to the Commission report as one voice but found it impossible, even with the extension, to achieve this objective. Therefore, it was agreed that stakeholders would submit their own response to the restructuring report [97].

The Corporation and St. Joseph’s supported most of the acute care recommendations and decided to continue with the clinical program integration plans [121]. The area in which there was significant disagreement with the Commission’s proposal was the proposed closure of the Chedoke site and the re-location of complex continuing care. It was considered that all complex continuing care beds should be sited on one location.

The DHC, in its response to the Commission, supported the Corporation in its concern about the closure of the Chedoke site and transferring of chronic care beds [119]. It was also concerned about the apparent lack of commitment to inclusive partnerships across primary, secondary and social care boundaries to ensure a responsive and functionally integrated health care service in Hamilton.

### ***The Community Develops an Alternative Plan for Complex Continuing Care***

The Corporation decided it needed to be proactive on the issue of complex continuing care services. It was unlikely that St. Peter’s Hospital could successfully challenge the Commission’s decision on its own. In April 1998, another report was submitted to the Commission which recommended a regionally integrated health care system for seniors, that St. Peter’s Hospital would manage all complex continuing care in the

region and that the University would develop a Research Centre in Ageing and Health. [125, 160, 200]. These recommendations were accepted by the Commission and became part of its final restructuring report.

### ***The Commission Finalises the Plan***

It took one year, from April 1997 to May 1998, for the Commission to complete and submit its final restructuring report to the Hamilton health community [129]. The report incorporated many of the stakeholders recommendations. Program and service allocations for the individual hospitals are shown in Figure 6.8.

**Figure 6.8: Summary of Acute Care Restructuring in Hamilton-Wentworth, May 1998**

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#### **HOSPITAL ROLES**

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##### **St. Joseph's Hospital**

- regional programs in nephrology, acute and longer term mental health, respiratory and thoracic surgery and complex continuing care
- ambulatory and urgent care services

##### **Hamilton Health Sciences Corporation**

- *McMaster site* - focus on high risk obstetrics and inpatient paediatrics
- *General site* - focus on cardiovascular sciences, neurosurgery and trauma. Designated regional rehabilitation centre.
- *Henderson site* - focus on oncology and haematology programs and serve as host hospital for the Regional Cancer Centre.
- *Chedoke site* - provide complex continuing care and acquired brain injury rehabilitation services.

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Source: Hamilton -Wentworth Health Services Restructuring Report, May 1998.

The Commission had projected that the estimated restructuring capital expenditure for Hamilton would be in the region of \$77.2 million while the speciality service and community based care reinvestment initiative would cost \$55 million [129]. In total for the province of Ontario, the Commission had recommended annual reinvestment of \$900 million in community based services and over \$1.4 billion for renovations and new construction in hospitals. This had been the largest capital spending program in the history of Ontario's public health care [128].

## **6.12 The New Corporate Hospital Archetype**

The new hospital Corporation's archetype is shown in summary form in Figure 7.1. The hospital's mission, value and vision statements prior to the merger are analysed and compared to those of the Corporation. Archetype transition is apparent. The Corporation was more about forging and managing collaborative community partnerships and providing data to support both clinical outcomes and funding expectations. These underlying values and beliefs support the emergence of a new hospital archetype which started out as a patient focused service and has evolved to one that is now more performance driven.

### ***Structures and Systems***

The senior management team of the Corporation and most of the program directors were in post by 1999. A new Chief Operating Officer position was created, freeing the CEO from operational responsibilities thus allowing him to have more time to work with the Board and the medical staff, nurture better relationships with the University and community agencies and to oversee the hospital restructuring as instructed by the Commission [127].

The program management model was being implemented across the hospital sites and this initiative was now suffering from a number of teething problems. First, it demanded an enormous amount of time and commitment by the staff involved. Secondly, implementation of the radical change process can be expected to take years, not months: a number of researchers have suggested that not less than three years is required to gain an understanding of how such changes are proceeding (e.g. Nadler

and Tushman, 1989; Huber and Van de Ven, 1995). This protracted period of change puts enormous pressure on both staff and patients. The message from frontline staff was that the downsizing in the middle management structure had been too severe with many cross-site appointments. The span of control of these managers and number of staff reporting to them was unrealistic [109]. As reported by one of the Clinical managers:

‘..you know you’re in trouble when your own staff were now being admitted to the ER with chest pains and other anxiety disorders straight from work on the ward and long term leave no longer meant a few weeks we were now talking months. It was also reported by HR that the hospitals insurer (staff benefit package) had reported a substantial rise in anti-depressant prescriptions for staff.’

Another question raised about program management would be the number of programs across the organisation and whether some of these should be consolidated. It would become apparent that there was considerable inequity in both the size and resources available to some of the programs [111]. The program re-design teams also thought there were too many programs. It was decided that some programs could be collapsed into other streams of care and others would have to be closed and transferred to other service providers in the community.

### ***Interpretive Scheme***

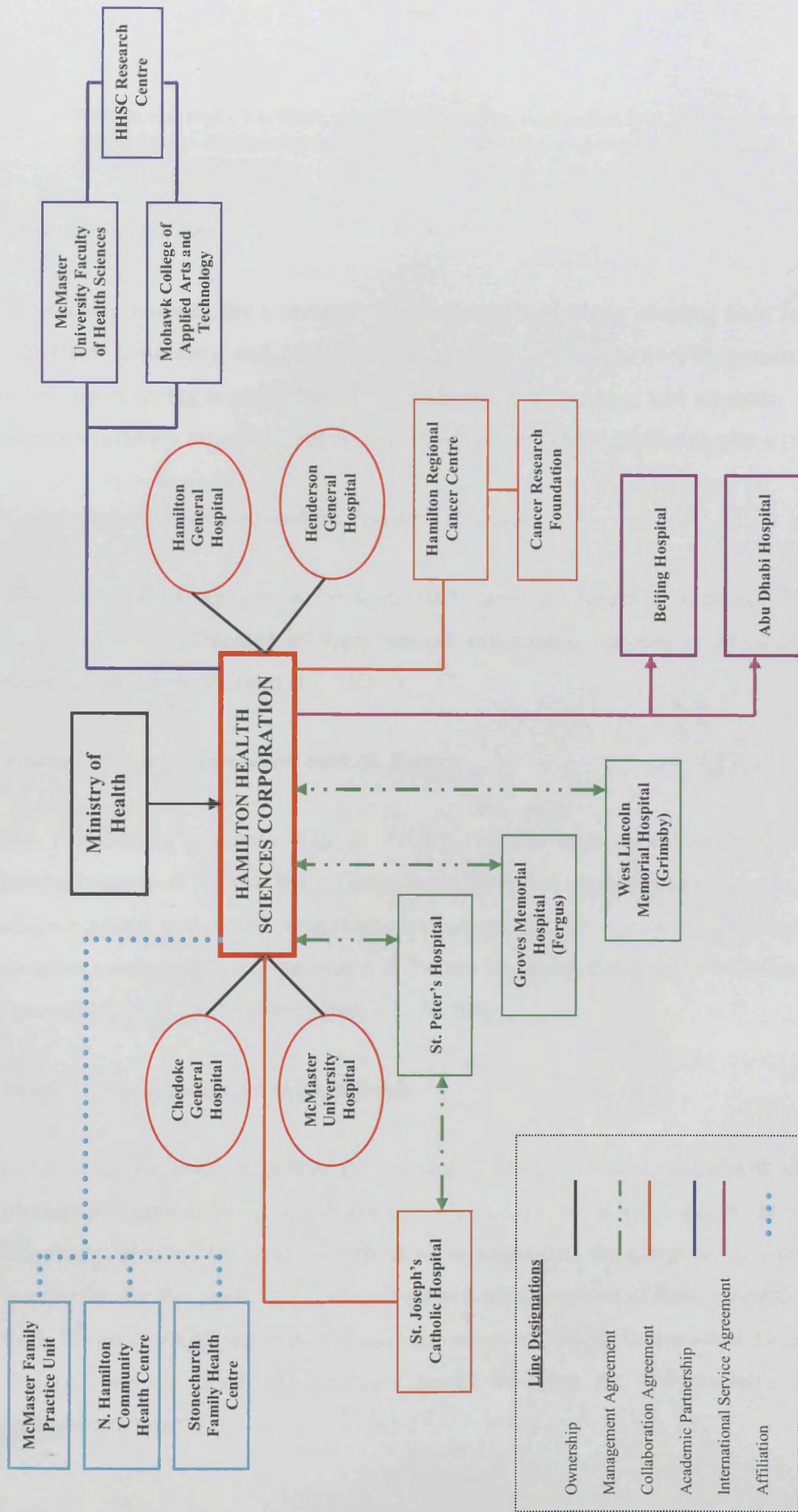
The Corporation’s interpretive scheme was characterised by a focus on performance - driven service (quality and efficiency), organisational autonomy, and the role of a major regional provider.

### ***Collaborations and Alliances***

The Corporation was developing into a networked organisation as its organisational affiliations, collaborations, strategic alliances, management service contracts and joint ventures got under way [123]. Refer to Figure 6.9 for the new configuration of Hamilton Health Sciences Corporation.

‘So we now have the whole management gamut within this new organisation.’  
(Hospital Vice President)

Figure 6.9: Hamilton Health Science Corporation - Configuration After Merger, 1996





‘Our model really has been one hospital on four sites rather than four hospitals with a shared administrative structure – in other words we are a new hospital.’  
(Hospital Board Member)

### ***Regional Affiliations***

As teaching hospital, the Corporation’s predecessors had long standing links to both McMaster University and Mohawk College, both of which were responsible for providing on-going medical and affiliated health care teaching and research. They were also actively involved with the numerous Research Institutes in Hamilton [133].

### ***Collaboration Agreement with St. Joseph’s Hospital***

The collaboration agreement between HCH and St. Joseph’s, inherited by the Corporation, was designed to share support and clinical services in an attempt to reduce costs and duplication [133, 145].

### ***Strategic Alliance Agreement with St. Peter’s***

The Corporation’s alliance with St. Peter’s Hospital arose naturally through their joining together to respond to the Commission’s original restructuring proposals. This alliance would lead to the consolidation of service for the care of seniors, including complex continuing care, long term care, homes for the aged and the development of a research institute for the elderly [160, 163, 164, 200].

### ***Hospital Management Service Contracts***

In 1997, the Corporation entered into management services agreements with Groves Memorial Community Hospital (Fergus, Ontario) and West Lincoln Memorial Hospital (Grimsby, Ontario). Under these arrangements the Corporation would be responsible for the day-to-day management and administration of these hospitals [123]. Each hospital would retain its separate governance through independent Boards of Trustees but the chief administrators would be from the Corporation’s senior management team [133].

## *International Joint Ventures*

During 1998, the Corporation entered a contract with InterHealth Canada Limited to act as a consultant to assure the implementation of appropriate health care standards in the development of the first private hospital to be built in Beijing [77]. This hospital would provide medical and health care services primarily but not exclusively to the expatriate population in China. The Beijing Toronto International Hospital project would provide a base consulting income plus performance bonuses when the project was completed [77]. Another international hospital project was also undertaken in Abu Dhabi. These international business ventures were a first for acute care hospitals in Ontario.

### **6.13 Financial Problems**

Many of the stakeholders interviewed thought in retrospect that the Task Force had been right to recommend closure of one of the acute hospitals, and that it was simply not feasible to run and maintain four acute hospitals in Hamilton. Other cities in Ontario of comparable size had fewer ERs and fewer acute hospitals.

In common with all hospitals across Ontario, the Corporation experienced significant financial problems following the Bill 26 restructuring reforms. As of October 1998 the Corporation's operating deficit was around \$38 million. A deficit of \$42 million was predicted in the operating plan of April 1998, if estimated wage increases and Y2K costs were included [72, 89, 149, 145]. The premium of operating four sites had increased staff costs by about \$10 million compared to other Ontario hospitals of similar size [Loop, Oct 98]. The breakdown of the \$38 million deficit can be seen below:

**Table 6.1 Hamilton Health Sciences Corporation - 1998 Deficit**

<b>Deficit Source</b>	<b>Amount</b>
Carried forward from the 1997 deficit:	\$12m
Decrease in revenue:	\$4m
Increase in costs for wages and on-going projects:	\$22m

Source: Loop Newsletter, October 1998.

There was no doubt that the restructuring of Canada's health care system had been an unprecedented experiment in social and organisational change, carried out in what was a very short period of time for a field so complex. Yet further efficiencies and cost reductions would need to be found, in a way that would not jeopardise patient care. The Corporation had already informed the Commission that its benchmarks were too aggressive and in order to meet these targets a cost reduction plan would have to be implemented which would affect patient care and also necessitate more staff lay-offs [74, 75, 133].

In April 1999, the Corporation finally received the financial contribution to restructuring costs that had been promised by the MOH back in December 1996, in the form of a one-time grant for working capital and merger related costs of \$25 million, an incremental base funding adjustment of \$7.7 million, and an additional funding of \$9 million tied to new programs, and extra funding to support the Y2K initiative [155]. This additional money meant that the Corporation's 1999 fiscal year would now end with a deficit of \$10 million instead of \$42 million.

In October 1999 the MOH initiated an Operational Review and Clinical Audit to determine reasons for the financial deficit and to develop a multi-year recovery plan to bring the Corporation back to a balanced budget position [155].

## 6.14 Summary

In this case, the threat posed by Bill 26 of compulsory closures or other restructuring of hospitals in Hamilton caused the three acute hospitals and other stakeholders to adopt a voluntary merger of two of the hospitals and a collaboration agreement involving the third. These measures successfully avoided any compulsory restructuring being imposed by government agencies or independent review bodies, and resulted in an archetype transition from the patient-centred General Hospital form previously operated by the merging hospitals to a Corporate archetype on which the new hospital formed by the merger was based.

Over a matter of only months the merger was negotiated, agreed, planned meticulously, approved by the MOH and initiated. Implementation began immediately following the MOH's approval and was pursued notwithstanding that the merger had yet to be evaluated by the Commission and may not have satisfied its requirements for savings and restructuring. There were no reversals, delays, periods of inertia, or shizoid positions at any time and thus a transformatory track of change was followed at revolutionary pace. When a possible obstacle to the merger appeared, in the form of antagonism between hospital chief executives, both were immediately removed from the negotiation process. Analysis revealed that the new hospital showed remarkable capacity for action in the face of severe implementation problems including resentment among some front line employees.

An interesting feature in this case is the high degree of co-operation between medical professional and managers: professional autonomy was never challenged, even under the new Corporate archetype. This probably reflects the tradition in Ontario (and indeed in the other Provinces) of medical professionals occupying management positions and often holding managerial qualifications such as MHA or MBA degrees. Mention has been made in Chapter 2 of the growth of 'commercialised professionalism' as a possible explanation for the resilience of sedimented archetypes. This case perhaps illustrates 'managerial professionalism'.

What is particularly interesting about this case, however, is the fact that the hospitals and other stakeholders were given the opportunity to come up with their own solution

locally to the problems addressed by Bill 26, for consideration by the Commission. The MOH as ultimate funder of the hospital system had the power to simply close hospitals down, but as was recognised by some interviewees, adopted a politically astute stance by interposing two levels of independent review (the provincial Commission and the local Task Force). This is a manifestation of social skill going somewhat further than Fligstein's example of letting others think that others are in control. In this case, control was, to a degree, actually devolved to the stakeholders, in the form of an opportunity to come up with their own plan rather than have one imposed on them.

Social skills apparent in the case were of a positive nature: brokering, for example. Skills oriented towards manipulated or coerced co-operation (such as agenda-setting, isolation of opponents) were not apparent or needed, reflecting the field - wide co-operation between stakeholders which in turn was enabled by the way in which the MOH chose to exercise its power.

## CHAPTER 7

### COMPARATIVE REVIEW OF THE CASES

#### 7.1 Introduction

In this chapter the hospital cases will be compared in relation to the role and interaction of government agencies and stakeholder groups in the pre-merger consultation process and the post-merger organisational restructuring and service integration stage. These changes will then be further examined in terms of whether a new organisational form has emerged as a result of the restructuring agendas.

In the English case the reform agenda was controlled from the top down and the government (through its Regional and District Health Authorities) was actively involved at every stage of the change process. In contrast, reform in the Ontario case evolved from the bottom up, with the local community taking responsibility for service re-design and change. In each case stakeholder groups and key actors were described in reference to their individual power positions and by the political alliances that they forged in the wider health care community. The interaction between these groups provided insight into the power dynamics that would shape the pre-merger change process.

There were certain key events in each case whereby groups of actors challenged the political power and control of the government, resulting in either division or co-operation between groups. Conflict emerged between groups in the English case while powerful coalitions developed in the Ontario case. In the Ontario case solidarity among the health care community and the public prevented two hospital closures and supported a voluntary merger. The conflict within the health care community in the English case was largely attributable to the control and manipulation of the pre-merger review and consultation process by a Regional Health Authority whose primary goal was to close the NGH.

With regard to organisational restructuring and service re-configuration, the hospitals involved in both countries went through several transitional management stages before the final structure emerged. The re-design and implementation of the program management and clinical directorate structures were based on project management

principles in both instances. However, the integration of staff and the restructuring of board and senior levels of management were done differently in each case. In the Ontario hospitals, a new organisational archetype, which we will call the multi-site networked hospital (with more of an entrepreneurial culture than its predecessor) emerged from the change processes. In Figure 7.1 the researcher compares the original *general hospital archetype* with the new *multi-site hospital archetype*. In contrast, the new English hospital structure retained many of the fundamental characteristics and features of the RVI Trust structure, and was not a new hospital archetype, but simply an enlarged and somewhat elaborated version of the RVI Trust.

A merger typology is developed to demonstrate the relationship between the research findings and the constructs of archetype theory and Fligstein's ideas. The first part of the typology highlights the power dynamics during the pre-merger phase and the second part focuses on archetypal development in the hospitals. This typology can be seen in Figure 7.2.

## 7.2 Contextual Comparison

An appropriate starting point for comparing the cases is what Greenwood and Hinings (1996) call the "exogenous variables" of market and institutional context.

### *Market Context*

In both cases there was considerable upheaval in the acute care sector. The acute care system had either failed to respond, or was responding too slowly to the changing trends in health care delivery. These advances ranged from new medical technologies and practices to a greater public awareness and demand for better service. The prevailing market themes in health care were both influenced by politics, competing demands for resources and a growing need for more community based programs and services.

In Newcastle, the service delivery model for acute care had remained basically unchanged and unchallenged since the Freeman Hospital was built in the 1970s. There

were serious problems with hospital services in Newcastle including lengthy waiting lists, inadequate use of resources, poor service planning, a significant backlog in building maintenance costs and financial pressures resulting from inefficient organisation of services. In Hamilton, like the rest of Ontario, hospital resources were being used to maintain hospital surplus capacity while other needs were increasing, and in some cases remained unmet, including the need for increased home care, community mental health and long-term care beds, and for different hospital services such as sub-acute care, rehabilitation, MRIs and other highly specialised and costly services.

The Ontario provincial government was spending 52% of its health care budget on hospitals; similarly the British government was spending 51% of its health care budget on acute services (Mhatre et al., 1992; Burke et al., 1993 and Baggott, 1994). Both governments had adopted a policy of radical re-shaping of health care services to improve quality, range and cost-effectiveness, with a significant redirection of funding from the acute hospital sector into primary and community health services. In both cases, the acute hospitals were facing a substantial reduction in government funding.

### *Institutional Context*

In both cases, the hospitals were multi-site and provided a range of services for their respective communities. There were two acute care hospitals involved in the merger in Hamilton (Chedoke McMaster and Hamilton Civic), and two acute care hospitals involved in the amalgamation of acute services in Newcastle (Royal Victoria Infirmary and Newcastle General). These organisations were also broadly similar in size, particularly in reference to bed count, services provided and budget.

In Newcastle, following the introduction of the internal market and the split between purchasers and providers in 1991, the hospitals were required to negotiate service contracts and funding with nine different Health Authorities. Whilst this arrangement was somewhat more complex than that in Ontario (see Figure 4.3), the cases are comparable in terms of hospital funding because ultimately hospitals in both countries are primarily funded by the government through public taxation.



The major difference between the hospitals in each case was the formal governance structure. In Hamilton, all the acute hospitals were governed by independent, autonomous boards. In Newcastle, the RVI and Freeman Hospitals were self-governing trusts, and therefore broadly comparable in terms of autonomy to the Hamilton hospitals. However, Newcastle General Hospital was refused trust status and was still a Directly Managed Unit of the Newcastle Health Authority. Therefore, it is arguable that NGH was not a “self directed organisation” but only part of another organisation, the Newcastle Health Authority. In addition to being deprived of official ‘trust status’ , NGH as a DM unit within the NHS was subject to what many at the sharp end saw as

“oppressive top-down management practised in what many regarded as the biggest bureaucracy in Europe” (Caines, 1993:130).

More importantly, from at least as early as September 1992 (several months before the launch of the Acute Services Review), NGH was not invited to take part in any key discussions between the Regional Health Authority and the Chief Executives of the RVI and Freeman hospitals concerning reconfiguration of acute services in Newcastle, and only became aware of any governmental proposals for change (the “Larry document”) when the plans were published in the local newspaper following a report leak to the press. In short, whether or not NGH could be considered an “organisation”, it did not in any event have the capacity to respond to the market pressures for change independently of the RHA.

### **7.3 The Review and Consultation Process**

Public health care sector review and consultation can be defined as a process in which the government initiates a review of the sector with a view to bringing about some form of change, and in which stakeholder groups provide government agencies with feedback in the form of written reports or verbal presentations on a specific issue or proposed change that may affect the stakeholders’ organisations or services, or specific patient groups. There appears to be no comparable model in the private sector.

If this *formalised feedback mechanism* is unique to the public sector perhaps it is an attempt to show the public that the government is attempting to be *transparent* and

perhaps even *accountability* about public spending. In the health care sector the use of consultation recognises that many services or agencies have a reciprocal or interdependent relationship, so that changes in one organisation can often have an impact on the others in the same or a related sector. This is one reason why change in the public sector is so complex (Ashburner et al, 1996; Kitchener and Whipp, 1996 and Denis et al., 2001).

In the UK, the government's nation-wide change agenda was too ambitious and the health care sector had become overloaded with government initiatives. Hospitals were applying for Trust status, community services, hospitals and government departments were merging and a new primary care service model was being implemented in spite of all the other system change. All these initiatives were happening simultaneously across the health care system and each time a change was proposed a consultation process was initiated. Many consultation processes required input from the same stakeholder groups and stakeholders were often involved in as many as 15 consultations within a two-year period.

The consultation process in the Ontario case was not as complex. Although the provincial government's change agenda was ambitious in that it was proposing whole-system change in the long term, it was much more focused on the short term and advocated that change proposals should be initiated at the service level. The roles of the MOH and the independent review bodies and the community were clearly defined during this process. The MOH made a conscious effort to operate at arm's length from the community by appointing independent bodies to carry out the review and recommend service and organisational changes.

There were only three consultation processes in the Ontario case. The first was carried out by a local review body and was focused on system and service change across the local health care community in Hamilton. The second review focused specifically on the proposed hospital merger between two of the main stakeholders, HCH and CMH. The third was a scaled-down repeat of the first, this time carried out by a provincial review body. It is important to highlight that these consultations were all focused on changes that would directly affect the stakeholders involved in the consultation process, whereas many of the English stakeholders were involved in

consultations about services and organisations external to their immediate service boundaries.

#### **7.4 The Role of the Government Agencies in the Review and Consultation Process**

The British government (through the Department of Health) and the Ontario provincial government (Ministry of Health) were respectively responsible for initiating the reforms in the health care sector, and both had decided that acute care hospitals would be the primary target for service rationalisation. Both governments adopted a formalised and structured approach to introducing change. The government would appoint a review group drawn from the local health care community to evaluate the present hospital configurations and recommend restructuring options, and health sector stakeholders were invited to contribute to the process through written reports, presentations and public forums within prescribed time limits. This basic framework for consultation was similar in both cases. However, there were substantial differences between the cases with regard to the politics underlying the composition of the review group and its approach to the consultation process.

The Acute Services Review group, in the English case, consisted of district and regional government representatives and senior managers from the acute care hospitals. Thus the majority of this group's members were from government-based or funded agencies and was committed to the RHA's change agenda. The RHA was actively involved in negotiations throughout the change process at both the governmental and service levels. The role boundaries between the RHA and the service providers were ambiguous. As a result, the RHA was seen to be both over-involved and politically manipulative during this review period.

Whilst in the Ontario case, the HATF membership consisted of a cross section of independent local representatives from the community, who had no vested interest in any of the health care organisations in the community. This was a strategic decision on the part of the MOH designed to separate politics from the decision-making process at the local service level. The HATF was appointed to evaluate local services and make recommendations to the provincial HSRC, an independent body with the power to make final decisions on restructuring. The MOH chose not to be directly

involved in the restructuring process, and did not want to micro-manage service level change, which they believed should be a self-directed process.

The respective approaches taken by the review bodies in both cases differed. In Newcastle, the Acute Services Review began in January 1993 and the final decision of the Newcastle Health Authority was announced in November 1993. The time allocated for public consultation was three months. The Newcastle Health Authority's consultation document was 20 pages in total. It contained brochure-style general information, lacked important information and contained misleading statements with regard to the outpatient services planned for the NGH site. The CHC, noting these deficiencies requested an extension of the time allowed for stakeholder responses, but was refused. In Hamilton, the review process began in March 1995, and the final document was completed and presented to the HSRC in May 1998. The time allocated for public consultation was eighteen months. Four consultation documents were produced, two by the HATF and two by the HSRC. These documents provided a total of 365 pages of detailed information and proposals. Newcastle Health Authority's consultation document did not refer to the arguments against the Authority's proposals (indeed, even before the consultation document was published, the Acute Services Review Group had already renamed itself the Implementation Group). The reports of the HATF and HSRC for the Hamilton hospitals presented a full analysis of all positions taken by stakeholders.

In the Ontario case the MOH and the community worked in parallel. The provincial government gave the HSRC the power to restructure acute hospital services, and remained in charge of the reform agenda for the duration of the process. The community was responsible for proposing and implementing change at the local level. The only time the MOH became involved at the local service level was when a community decision might impact on government funding arrangements or any existing service agreements. The role boundaries between the MOH and the Hamilton community were separate and each operated autonomously. This was evident when the community was able to overturn a MOH decision regarding the restructuring proposal. This reciprocal relationship between the provincial government and the local health care community continued into the hospital restructuring period.

This contrasted dramatically from the English case where the process was dominated by the RHA at every level. The RHA and the DHA led the Acute Services Review. They chose simply to overrule many of the concerns raised by their community stakeholders regarding the closure of NGH and its impact on local residents. This was not really about meeting the health needs of the community; it was about government spending. There is clear evidence of governmental manipulation of the consultation process by the RHA and the Department of Health. First, they undermined the power base of NGH by refusing it trust status twice, for political reasons. Second, the RHA strengthened the RVI's hand by passing it sensitive information about the intentions of NGH, and by merging Hexham General Hospital with the RVI. Third, the Secretary of State, when he received the report submitted by the CHC appealing the proposed closure of NGH, was already preparing a recommendation that a new trust be established on the NGH site to provide ambulatory care services together with rehabilitation and therapy services. The RHA and DHA were both key players in the review process and had a significant role in the restructuring process as members of the Implementation Group.

In the Ontario case, the creation of independent review bodies (HATF and HSRC) to implement the provincial government's restructuring policy pre-empted any political bias and gave the local health care community both input and responsibility in restructuring decisions. This approach actually empowered the local stakeholders to challenge, and successfully negotiate changes to the proposals of these review bodies.

## **7.5 Stakeholder Groups**

Although similar stakeholders were involved in making key decisions and leading the change agendas in both countries; it soon became evident that the difference in the merger outcomes lies with the composition of each of the groups, the vested interests of the participants, their political partisanship and their respective role in the community. (see Figure 5.2 and Figure 6.2).

### ***The Acute Hospitals***

During the pre-merger phase, three hospitals were involved in the Acute Services Review in the English case. The relationship between these hospitals was clearly

demarcated. The RVI and the Freeman hospitals had both been awarded Trust status, which brought with it many financial and managerial freedoms and a degree of autonomy from government control, while NGH was still a Directly Managed Unit. The respective power bases of these hospitals were therefore unequal, and NGH's position was compromised from the very beginning of the Review. Encouraged by the RHA's invitation to prepare the report that became known as the "Larry" document, the RVI and Freeman hospitals formed a political alliance and conspired on several occasions against the NGH. In contrast, the three hospitals in the Ontario case were equal in terms of financial standing and power. There was, nevertheless, the threat that one would be targeted for closure, and HCH and SJH decided to negotiate a formal alliance. This collaboration was intended to be both a cost sharing exercise and a way of avoiding closure.

An interesting difference between these hospital alliances (apart from the RHA's involvement in encouraging the alliance in the English case) is that the RVI and the Freeman participated in what can be seen as an aggressive alliance to further weaken an already weakened NGH, while in the Ontario case HCH and SJH formed an alliance to ensure their survival rather than to disadvantage CMH. This alliance was therefore defensive in nature. The fact that these hospitals were successful in avoiding closure indicates that strategic alliances or collaborations can be a useful tactic by stakeholders.

In each case, the hospital that had the strongest link with the University medical school also had the weakest relationship with the local population, yet saw itself and indeed was perceived by others as having more political leverage and power in the merger negotiations than the other hospitals. CMH and the RVI each had the advantage of being located at the same site as the local university medical school.

The role played by senior hospital management provides another interesting comparison. The conflict that existed between the respective CEOs of HCH and CMH severely hampered their ability to address any service reconfiguration proposals collaboratively. The decision to merge these hospitals was made by the respective boards, who felt that a decision of such magnitude was a governance issue and not one to be left to the CEO. This is in sharp contrast to the English case, in which the decision to take over NGH was initiated by the RVI's CEO. The Ontario hospitals

had a longer history of professionally qualified managers and autonomy than did the English hospitals. The English hospital board of trustees was not as powerful or experienced as its Ontario counterpart, and the real leadership and power in the English hospital lay with the CEO. This may well explain why the merger agenda in the Ontario case was board-driven, while the hospital take-over in the English case was CEO-driven.

### ***The University***

The Universities in both cases were perceived as powerful stakeholders and as noted above the hospitals that shared premises with the medical schools were ascribed higher status and more power because of this association. At the start of the merger process, both Universities kept a low profile and both focused primarily on issues pertaining to medical education and research. In the Ontario case the University was initially excluded from the merger discussions with the hospital boards because it was thought it would be accused of prejudicing the outcome. The University in the English case was involved in the change process throughout the consultation period.

In the English case, the University was a member of the RVI coalition. The University took the lead at the Seaburn Workshop and proposed Option 6, which supported the government's primary care initiative, strengthening the position of the RVI and sealing the fate of NGH (see Figure 5.3). The University insisted it was acting in the best interests of all parties, but this is open to question - especially from the viewpoint of NGH. In the Ontario case, the University was the leading partner in the AHCN group and was instrumental in opposing the closure of SJH. The University kept a low profile during the merger discussions between CMH and HCH but when an impasse was reached between the two hospitals it was approached to act as a mediator. Thus the Universities in both cases were powerful politically, and instrumental in directing and influencing the outcome in the hospital merger and take-over.

### ***The Medical Profession***

The medical profession took a totally different approach to change in the two cases. In the English case the medical community remained committed to their respective

hospitals. The doctors from NGH fought to save the hospital from closure. The doctors from the RVI remained committed to the position of the RVI. These two medical communities were unable to reach any professional compromise to resolve the conflict that existed between their respective organisations; indeed there was no attempt to work co-operatively during the pre-merger phase. The medical community as a whole was able to endorse and support only the position of the University medical school, on relatively non-contentious issues pertaining to undergraduate medical training and research. It was only after the final decision to close NGH that the doctors collaborated to take a lead in the service reconfiguration process. The conflict between these two medical communities was later addressed during the organisational integration phase.

The Ontario medical community approached the merger more as an opportunity to re-assess medical services across hospital sites and to propose and secure professional changes, while the English doctors saw the proposed changes as a threat to medical staff and patient services. The Ontario doctors worked co-operatively across hospitals and were the first internal stakeholder group to meet during merger discussions. Their goal was to finalise the medical by-laws for the new hospital. The medical groups recognised their own potential power in both protecting their professional interests and at the same time assisting in moving the merger forward. Their collective action across both hospitals gave them significant political and clinical power and profile during the development of the new organisation. In the English case, the doctors (including those of the RVI) were less optimistic about their ability to have any real influence on change in the new hospital, and felt that they faced a very uncertain future.

### ***Community Stakeholder Groups***

In both cases the consultation process involved a wide range of community stakeholder groups including local government councils, health service organisations and different patient groups.

In the English case, the health care community was divided on whether to support the re-configuration of acute care services onto the RVI site and the closure of NGH. Stakeholder groups operated independently (that is, in isolation from each other) and



were encouraged to do so by the RHA, even though many identified the same concerns and issues regarding the re-structuring of acute care services across the city. The only attempt to co-ordinate action was that made by the CHC in respect of various small community groups. It led the campaign in support of NGH and ultimately appealed directly to the Secretary of State. The RHA's decision to close NGH was however a political fait accompli.

In the Ontario case, the local health care sector was united in opposition to the recommended closure of SJH and re-location of HCH. This was evident in the reports submitted to the HATF and the political pressure that the community brought to bear at the DHC public meeting. The driving force behind this united front was the AHCN. This powerful stakeholder group consisted of a cross-section of health care and community leaders. It was successful because it had the support of key organisations across the local health care community, and through the collective power and solidarity of its members the AHCN was able to persuade other stakeholders that there was an alternative option to the recommendations presented by the HATF, with regard to acute services and to persuade the DHC to reject those recommendations.

## **7.6 Key Events in the Consultation Process**

In both cases there was a key event in the consultation process that can be seen as a political turning point, in the sense that the event provided a platform for a highly visible manifestation of the strategic use of power by certain actors against their opponents.

In the English case the two-day Seaburn Workshop was the stage for what witnesses described as a brutal attack by the CEO of the RVI on NGH. At this meeting the CEO of the RVI, buoyed by the support of the RHA, used the material presented to discredit not only the financial viability of NGH but also the managerial capability of its leadership. This humiliation was inflicted in the presence of other key actors, as leaders of organisations attended the workshop from both purchaser and provider sides of the local health care sector. The University, which clearly supported the RVI, took this opportunity to propose Option 6 (transfer of all acute services to the RVI and

Freeman) as a solution more palatable to NGH than outright closure. There was no similar event in the Ontario case, where stakeholder interaction was invariably collaborative.

The single most significant event in the Ontario case was the re-convened public meeting of the DHC at the Hamilton Convention Centre, attended by over 800 people. The proceedings at this meeting were so impassioned and the pressure on the Council members so great that they felt unable to vote for anything other than the status quo. In contrast, no public meeting of this scale or influence was held in the English case, where no less than 19 public meetings were convened in districts within Newcastle, in late July and in September, with attendances ranging from 5 people to 40 people [150].

## **7.7 Organisational Restructuring**

Following the final decision to merge, both cases focus on organisational restructuring and service re-configuration. The approach taken to restructuring organisational governance was markedly different in the cases, yet similar approaches were taken to establishing transitional management structures and to long-term organisational changes.

In the English case, there were no changes in the membership of the board, the trust leadership, the senior management team or the name of the hospital. The RVI trust board membership and numbers had remained the same since 1992 even though the size of the organisation had almost doubled and now incorporated services previously managed by two other hospitals. The Board was directly responsible to the NHS Executive in the Department of Health. It comprised of a chairman, 5 non-executives members and 5 RVI executive members. The Secretary of State had appointed the Chairman and the non-executive members. It was observed that only one out of the five non-executive members could be considered as having commercial experience and expertise. This meant that from a power perspective the board would have had little influence on the actions of the CEO. The major outcome of the restructuring initiative was that the CEO of the RVI had led the change process and the only observed changes were that NGH no longer existed and a majority of its clinical services would now be managed by the RVI.

The governance structure in the Ontario hospital was very different. The two hospital boards from CMH and HCH formed the Merger Transition Committee and jointly led the merger. After the decision to merge, the first task undertaken by the Merger Transition Committee was to establish a new board structure. The new hospital, HHSC, was set up as a corporation with membership in two categories, annual membership and honorary membership with membership rights, obligations and eligibility criteria set out in the by-laws of the corporation. The Board of Trustees would be elected at the annual meeting of HHSC. Under transitional arrangements all the existing members of CMH and HCH prior to the merger would be accepted as honorary members and members of the board of trustees would be accepted as annual members of the new corporation. The first board of trustees for the new HHSC would consist of twenty-six trustees made up of 18 newly elected trustees from the current boards of both hospitals and new members from the community and the remainder would be ex-officio directors. The first task of the board would be to decide on a new name for the hospital and to hire a new CEO with no existing connection with either of the merging hospitals. These activities clearly signalled the beginning of a new organisation.

The decision to call the new organisation the Hamilton Health Sciences Corporation was important on two counts. First, a change in name meant that this would now be regarded as a new organisation and not an extension of either of the merging organisations. Second, the decision to use “corporation” instead of “hospital” reflected a major shift in the underlying interpretive scheme. The term “corporation” was associated more with business and private sector organisations, and its use for a public sector hospital was a new concept.

### ***Management Structure Re-Designed***

The original middle management structure of the RVI had changed when an interim organisational structure was proposed in 1994, when the RVI applied for joint trust status with Hexham General Hospital (see Figures 5.4 and 5.5). In 1995, following the final decision to close NGH and to transfer clinical services to the RVI, another transitional management structure was established in an attempt to integrate some of the remaining NGH staff into middle management (Figure 5.6). The structure was

eventually finalised in 1997. The final organisational structure had the same senior management executives as the original RVI even though the organisation had integrated many of the clinical services from the NGH and had almost doubled in size. The new organisation had expanded and delegated more responsibility to the middle management level of the hospital. This final structure, from the middle management level down, was very similar to that of the new Ontario hospital.

It is important to highlight that the senior management team of the RVI did not change. The office of Finance Director would now carry with it the additional title and role of Deputy CEO. The CEO would now be undertaking much broader managerial roles and would be more externally and strategically focused while the Deputy CEO would be more concerned with the day to day operational issues of the organisation. This change in the roles and responsibility of these two key leaders in the organisation was in response to the changing political economy and the expanded size of the new organisation.

In the Ontario case, an interim senior management team was appointed from both the merging hospitals. All 23 senior executives would meet initially to share information, and from these 11 were selected to lead the hospital through the transition period (Figure 6.5). The organisation's transitional structure was similar to that of the two predecessor hospitals. This was a deliberate decision taken so as to minimise disruption to staff and patients during the restructuring phase. In 1999 a final 8 executives were selected from the 11 to form the new management structure and to lead the corporation in the long term (Figure 6.6). The final organisational structure had half the original number of senior executives even though the organisation had doubled in size with the merger (as in the English case). The organisation had fewer managers, but each now had larger spans of control. Many interviewees believed that reducing the number of the senior management team was the only area where any economies of scale could be achieved. Most of the benefit realised was in financial terms while, from a management perspective, serious problems were yet to develop.

### ***Approach to Service Integration***

When entering the restructuring phase, the hospitals in both cases were already undergoing re-organisation initiatives. The on-going re-development of the RVI site

and the re-engineering projects undertaken by both the HCH and CMH would further complicate the organisational integration process following merger. Health care in both countries was now adopting a more business-like approach and this was evident in their respective approaches to implementing service changes. In both cases a project management approach was adopted.

In the English case, a new project management department was established, which was responsible for the co-ordination, supervision and transfer of acute services between sites. A similar department was developed in the Ontario hospital called the Office of Integration. In each case the department's mandate was to set out the goals and objectives for the integration process and to put in place a framework by which service re-design and integration could be co-ordinated. The restructuring and integration of services from two predecessor hospitals into a single organisation operating out of several sites, while undertaking numerous re-development projects and downsizing staff numbers and services, was a complex process.

### *A New Approach to Service Delivery for the Hospitals*

During the restructuring phase, in both cases the hospitals introduced a new patient care model. The design and implementation of the program management and clinical directorate structure was a monumental task and posed many problems both internally and externally for the hospitals. This re-design initiative was costly and would take years to implement because many services required site re-development. The new patient care models had created a more decentralised management structure, which delegated more operational power to the program directors and managers. This new management structure was intended to make clinical services more responsive to the needs of patients and staff at the front line

In the English case, when the hospital services merged under the RVI there were 19 clinical departments at the RVI and 18 at NGH. This number of departments was eventually reduced and services were re-distributed between 9 clinical directorates (Figure 5.7). Medical consultants were now expected to take on a more managerial role in the newly formed clinical directorates. This was a major role shift for the medical profession. Many of the NHS staff placed into management positions had no training or previous experience. Doctors in the Ontario hospitals were used to holding

senior management positions and many of the CEOs in Ontario hospitals were medically qualified and also held management degrees. Senior management positions were seen as part of the career path for many Ontario doctors.

Both hospitals in the Ontario case were familiar with the program management model of patient care, and were already in the process of restructuring their clinical services at the time of the merger. HHSC's senior managers believed that a similar structure should be developed in the new organisation. The new program management model had 4 clinical portfolios with a total of 18 clinical programs (Figure 6.7). Several problems began to emerge as soon as the process of consolidating programs across the different sites was initiated. It became apparent that there was considerable inequity in both the size and resources available for some of the programs. Many considered that the downsizing in the middle management structure had been too severe, that there were too many programs and that the change time frame was too short.

It was found, in both cases, that the process of re-designing and re-allocating clinical services across sites was far more complex and time consuming than originally anticipated by both the government agencies and the senior hospital managers.

Another key observation was that the change process was far from cost effective. In fact in both cases the consolidation of services across the various hospital sites catapulted all hospitals into spiralling debt (see Chapter 3 , Table 3.1). Change on this scale requires investment and slack resources to cover the extra costs of new construction, renovations and site re-development. In both cases the government agencies also failed to anticipate the cost of staff redundancies and severance packages.

## **7.8 A New Hospital Archetype**

A new hospital archetype emerged in the Ontario case while the hospital trust in the English case was subjected only to system and structural adjustments which were not indicative of a new organisational archetype.

Prior to achieving trust status the RVI was managed by and accountable to the District Health Authority. The hospital focus was then more introspective, and lines of accountability were mainly confined within its own organisational boundaries (Figure 5.1). When the RVI attained trust status it was given more independence and power to manage service provision, invest capital and develop new innovative services. The take-over of NGH's clinical services resulted in an increase in the RVI's provision of clinical services and staffing but did not change the basic underlying values or functions of the hospital. The new clinical directorate structure was developed in part to accommodate the services taken over from NGH. The new RVI spanned three sites and its size had almost doubled (Figure 5.8). There were no significant changes in the underlying interpretive scheme or organisational structure to indicate that a new hospital archetype had emerged. The researcher concludes that the new RVI should be considered not as a new hospital archetype but as an expanded, evolved trust hospital.

In the Ontario case the new HHSC spanned four sites and was double the size of each of its two predecessor hospitals. The Corporation had nominated a new Board of Trustees, appointed a new CEO and selected a new senior management team. The focus of change was to maintain equal representation of both merged organisations at the management and clinical levels of the new organisation. The new underlying interpretive scheme was more business-oriented and addressed issues pertaining to cost containment, efficiency and service rationalisation. These values had a major influence on the new hospital as it continued to develop both beyond the boundaries of its local health care community and into other health care fields. The Ontario hospital emerged as a new organisational archetype, the multi-site networked hospital (Figure 7.1). HHSC developed a more entrepreneurial approach, as was seen with its collaboration agreement, organisational networking, management service contracts and international joint ventures with other health care organisations (Figure 6.9).

**Figure 7.1 Ontario Hospital Archetype Comparison**

<b>ARCHETYPE CHARACTERISTICS</b>	<b>HOSPITAL ARCHETYPES</b>	
	<b>General Hospital Model</b> (patient/service oriented)	<b>Multi-site Networked Hospital Model</b> (corporation oriented)
<b>Interpretive Scheme</b>	Patient focus service (quantity and throughput)	Performance driven service (quality and efficiency)
	Professional autonomy	Organisational autonomy
	Local service provider	Major regional provider
<b>Systems, Processes and Practices</b>	Annual resource increments	Fiscal insecurity (budget cuts)
	Bottom up management style	Slightly more CEO control
	Financial autonomy - restricted to non-profit activities and patient related practices	Increased financial autonomy-use resources to maximise value and promote economic development through commercialisation.
	Greater focus on internal functioning of hospital (in-patient services)	Greater focus on external/environmental issues (community and population service planning)
	Incremental changes	Radical changes
<b>Structure</b>	Medium differentiation and medium integration between clinical and managerial domains - doctors held senior management positions	Low differentiation and high integration between management and professional domains - increased managerial roles for doctors and nurses at middle management level
	Functional matrix based on medical speciality	Program management model – innovative new service delivery model of patient care
	Centralised control	Decentralised power and responsibility
	Two site management	Multi-site management
	Single hospital focus	Collaboration through networks, partnerships and alliances

Source: By Author



This major difference between the English and the Ontario cases may be attributable to the fact that the Ontario hospital was already at a different stage of development than the English hospital when the change process began. The Ontario hospital already had managerial independence from the provincial government and a higher integration of health professionals in management positions. In many ways, the pre-merger Ontario hospital was similar to the post-merger English hospital trust (Figure 6.1). This meant that the hospital was, by comparison with its English counterpart, strategically progressive, structurally receptive and politically ready to move toward a new organisational archetype.

## **7.9 Financial Problems Translate into Chronic Debt**

Hospital restructuring in both cases resulted in huge financial debt. The government agencies in both cases did not just underestimate the cost, complexity or impact of such massive re-organisation of health services, they were also responsible for inducing debt by withdrawing financial support in breach of promises to reimburse the hospitals for the costs of the restructuring. It was estimated by the DOH, in the English case, that the government would save £30m each year by reorganising the acute services. However, only a few months into the restructuring, several problems began to emerge and the RVI was facing the prospect of spiralling debt. There were additional financial pressures from the site re-development projects, the costs of which had already exceeded the government's projected annual saving of £30m. The disruption of clinical services had resulted in lost revenue and backlog maintenance costs were increasing. The service contracting process was breaking down and as a result, the Trust had an unexpected reduction in its income budget. The DOH had completely overlooked the cost of staff redundancies, and payouts had been grossly underestimated. But the biggest blow was when the government's promise to provide bridging finance to the Trust was revised and downscaled from £63m to £30m. The only reason why the new RVI did not have a huge deficit in its first year was because it was able to obtain £40m through the PFI scheme.

Similar problems developed in the Ontario case. As a result of unprecedented cuts in ministry funding, it had already been estimated that the hospital would face a \$60m shortfall in its next fiscal year (1997). This loss in revenue would have to come out of

the hospital's operations, which meant staff lay-offs, ward and bed closures and waiting lists for procedures while the hospital tried to find ways to raise non-ministry revenue. The hospitals had calculated that annually the merger would save approximately \$10m and the alliance with SJH would save about \$16m. The MOH had originally estimated the restructuring initiative to cost about \$83m but the HSRC later estimated the capital expenditure alone to be \$77.2m and service re-development costs to be around \$55m. These costs would be in addition to wage and benefits costs increases, drug cost increases, buying and maintaining equipment, creating a new integrated telephone and computer information system on all four sites and staff severance packages.

The provincial government had promised to release working capital for the hospital during the restructuring period in 1996 but the money was withheld until 1999. By then the hospital was already carrying a deficit of almost \$42m and had been forced to close more beds, reduce elective operating room hours, outsource services and consolidate clinical programs further, which meant more staff redundancies. This funding provided only temporary relief because the new hospital was unable to sustain the debt and by 2000 had a record-breaking debt of \$40m.

It can be concluded that government-induced debt had been a major contributing factor to the financial crisis evident following the restructuring in both cases.

### **7.10 Merger Typology**

The intent of this typology is to summarise the outcome of each case and to document the role of key stakeholder groups, the tactics used during the merger process and the nature of the emergent organisation. In Figure 7.2, the key characteristics of the English and Ontario cases are compared against the key theoretical constructs of both archetype and Fligstein's theories.

Archetype theory provides a basis for defining the end points of change. This means that an initial evaluation of the hospital's organisational configuration prior to the merger process allowed the researcher to establish a baseline of organisational functioning and structure (see Figure 5.1 and Figure 6.1). This comparison will allow

us to analyse the development of the new organisational form; the new multi-site networked hospital in the Ontario case and the evolved trust structure in the English case (Figure 5.8 and Figure 6.9). Fligstein's (1990) theory about power and social skill will allow us to assess and describe the power dynamics, characteristics of the government agencies and key stakeholders and their actions during the pre-merger phase of the cases.

**Figure 7.2 Merger Typology: Power Dynamics and Archetypal Development**

MERGER CHARACTERISTICS	MERGER CASES	
	ENGLISH	ONTARIO
	<b>POWER DYNAMICS</b>	
Stakeholder Response to External Pressure	Reactive	Proactive
Change Process	Contested	Co-operative
Stakeholder Approach	Independent Opposition	Collective Consensus
Merger Leadership	CEO Dominated	Stakeholder Dominated
Role of Government	Open-ended Involvement	Circumscribed Involvement
Government Intervention	Autocratic (Central Control)	Facilitative (Delegated Control)
Distribution of Power	Government and Elite Actors	Community and Stakeholders
Merger Type	Mandatory Merger or Take-over (Service Transfer)	Voluntary or Self-directed Merger
	<b>ARCHETYPAL DEVELOPMENT</b>	
Tracks of Change	Structural Adjustment	Transformation
Sequence of Change	Prescribed Restructuring	Emergent Process
Senior Management Team	Same Actors	New Appointments
Organisational Name	Predominant Hospital	New Corporate Entity
Service Integration Approach	Project Management	Project Management
Patient Care Model	Clinical Directorates	Program Management
Hospital Archetype	Trust Archetype (no change)	Multi-site Networked Hospital Archetype (new archetype)
Organisational Strategy	Managerial	Entrepreneurial

Source: Developed by Author.

The following relationships emerged in this research and are summarised below. These relationships are discussed in conjunction with the case material and theoretical constructs from the merger typology.

First, the behaviour of the government agencies had a direct influence on the actions of the stakeholders. The RHA defined the rules of interaction and established the role boundaries between the various groups involved in the merger process. The RHA had an *open-ended* arrangement whereby it was involved directly in stakeholder activity throughout the entire change process. Many of the stakeholders responded in a *reactive* manner and *contested* many of the change proposals, which they felt favoured certain stakeholder groups over others.

In the Ontario case, the MOH had a more *circumscribed* role. The MOH had clearly defined role boundaries. Its involvement was limited to specific activities. The stakeholders responded in a more *proactive* manner and were able to work *co-operatively* across the health care community. This restructuring process was perceived as an opportunity for self-directed change.

Second, the stakeholders' decision to either work *collectively* or *independently* of each other would determine how they would resolve their differences. In the English case, the RHA's proposal to close NGH split the health care community. The change process became highly politicised. In the Ontario case, the stakeholders were united in opposing the HATF recommendation to close SJH and the HSRC proposal to close St. Peter's Hospital. The community was successful in challenging and overturning these proposals because they were able to set aside their own agendas and reach a *compromise* on a change proposal that would benefit the community as a whole.

Third, the politics and behaviour of the RHA played a key role in establishing who would take the leading role during the merger process. The RHA deliberately arranged for the RVI to remain in a position of power throughout the change process. This power allowed the RVI to take the leadership role during the take-over and as a result the ASR became a *CEO-hospital-dominated* process. In the Ontario case, the MOH had delegated decision-making power to an independent review body and the local communities were expected to take both the lead in and responsibility for recommending changes. This led to a *stakeholder-dominated* process. The change process in the Ontario case was more *emergent* because the final decision was dependent upon the input of multiple stakeholders while the overall process in the

English case was *government prescribed* because of its autocratic manipulation by the RHA.

Fourth, the way in which the government defined its role and, through its agencies, interacted with community stakeholders determined the kind of merger that took place. The hospital merger or take-over was either *government-led or stakeholder-led*. The government-mandated merger in the English case led to a *hospital take-over* while the stakeholder-initiated merger in the Ontario case led to a *voluntary merger*.

Fifth, the process or track of change is an indicator of how the organisation will evolve, whether a new organisational archetype will emerge or the merger will only result in minor structural adaptations. The English case involved only a *structural adjustment* within the existing hospital archetype. The *hostile take-over* did not result in a new organisational archetype but in an *evolved trust*. The hospital merger in the Ontario case was a successful *transformation* and a *new hospital archetype* emerged, the *multi-site networked organisation*.

This hospital merger/take-over typology supports the outcome of this research. It would be interesting to see if this merger typology or framework could be applied to other hospital mergers or perhaps even organisations in other organisational fields in either the public or private sector.

## 7.11 Summary

This chapter compares the English and Ontario cases. Key points are raised about the role of the government and the interaction between stakeholder groups. Both cases indicate that the role of the government and its agencies was instrumental in determining the final organisational outcome. The autocratic and politically manipulative behaviour of the RHA resulted in a hostile take-over of NGH by the RVI. There was no change in the existing interpretive scheme and as a result no new organisational archetype. In the Ontario case, the MOH delegated power to independent review bodies and local health care communities. The merger process was stakeholder-dominated and a new organisational archetype emerged. This new multi-site networked hospital was supported by a new interpretive scheme.

The researcher was interested in applying and evaluating archetype theory and Fligstein's work on power, to see if these approaches could be used to analyse hospital mergers in the public sector. It was found that each theory on its own was insufficient to track and explain the change dynamics throughout the merger or hospital restructuring period. But used in combination these theories provide a reasonably comprehensive analysis of change in the hospital sector.

Creating a merger typology further tested the theoretical constructs and the data from the cases. This typology provides a framework, which attempts to capture the major findings in the research. The final chapter will identify the main outcomes of the thesis and address areas of future research.

## CHAPTER 8

### CONCLUSION

#### 8.1. Introduction

The focus of this research study was to analyse the approach taken by government agencies and the role of stakeholders during public sector hospital mergers. The two case studies were systematically compared: one hospital merger took place in Northern England and the other in the Province of Ontario, Canada. The purpose of this comparative work was essentially two-fold. The first part of the study would focus on tracking the merger process over time and analysing the differences and role of the actors during the merger and restructuring period. Whilst the second part of the research would attempt to identify any key changes in the structure, systems and underlying values of the hospital organisations and to determine whether a new organisational form had emerged as a result of the restructuring process. In the course of the research investigation, it became progressively apparent that in both cases the role of the government and the medical profession were key factors in hospital mergers.

Archetype theory was applied in combination with concepts derived from the work of Neil Fligstein, and this combination was found to be useful in analysing and explaining the change process in hospital mergers.

This chapter sets out the main findings of the research, identifies its limitations, and suggests what future research might usefully be undertaken in light of these findings.

#### 8.2. Research Findings

This research suggests that public sector hospital mergers can develop in very different ways even where, as here, the hospitals are of similar size and importance to local health care provision and the perceived need for reform is similar. The variations revealed in this research suggest a distinction between change that is “stakeholder-led” and change that is “government-led” and that these merger types can be defined in terms of three distinct but closely related factors:-



- (1) the government's approach to consultation with stakeholders, in particular the extent to which stakeholders are given the opportunity to influence and shape the changes decided upon or approved by the government;
- (2) the power dynamics and interaction between key stakeholders during both the consultation process and the post-merger restructuring process; and
- (3) the extent of government manipulation of any part of those processes.

The Ontario merger was found to be stakeholder-led and resulted in a new hospital organisation archetype. The English merger was found to be government-led and not to have resulted in a new hospital organisation archetype. There is a considerable body of literature indicating that change is more likely to be successful when those affected by it have ownership of the change process, and this research tends to support that proposition in the case of public sector hospital mergers. However, in order to establish whether the successful emergence of a new hospital archetype is more likely in the case of stakeholder-led change than in the case of government-led change, more cases need to be studied, and especially as in this study the researcher found no indication of any attempt in the English case to move the Newcastle acute hospitals from one archetype to another.

The research has also identified six major factors influencing the success of the merger process and outcome from an organisational perspective (merger economics, quality of care and patient outcomes and satisfaction are not the focus of this study).

### **8.3. Government Approach to Consultation**

Two very different approaches to consultation emerged in the cases. In the English case, the consultation process was government-dominated and was conducted between the government (at all levels) and the stakeholders. In the Ontario case, the process was based in the local community and conducted between independent review bodies and local stakeholder groups.

#### ***English Case***

In the English case the government retained power and controlled every step of the merger process. Through the RHA and the DHA there was direct government

representation and leadership on every merger or work group committee. The review and consultation process was conducted over a period of nine months only, of which only three months were given for public consultation. Stakeholder groups were given little information, with no detailed plan regarding the proposed change, no timelines, and no costings or projections; and the consultation document did not address any of the arguments against closure of NGH or the community's concerns. It is clear from the data collected that the holding of numerous small public meetings was a political exercise on the part of the government to appear concerned about community input when in fact the meetings were poorly publicised and held for the most part in the summer holidays. It is hardly surprising that attendance was low and political engagement weak.

Stakeholder groups, other than the CHC, never attempted to collaborate across the community. As a result, reports were submitted independently and information across these groups was not shared. The government through the RHA and DHA was the only actor who knew what issues and concerns were raised by and across the community. Many of the stakeholders interviewed felt that the timeframe of the consultation period was unrealistic but the DHA would not grant any extensions around the submission deadlines. Surprisingly, there was no feedback mechanism built into the consultation process. Dialogue was rare and only considered if requested by the stakeholder. If a stakeholder raised a concern, the reply would often be given informally by letter to that stakeholder, and there was no indication that any of the issues raised, or responses by the government, were made available to the public or other stakeholders. It was noted that on one occasion, the CHC asked the DHA for clarification and further information on important matters but the DHA was only prepared to give a verbal response two days before the meeting at which it would be voting on the very issue that the CHC had questioned. This approach on the part of the RHA and DHA was typical of the kind of control the government exercised over information. The stakeholders had no clear role in this process and were not empowered to any significant degree.

Another significant finding was that stakeholders were expected to be involved in several simultaneous consultations across different services. The government's overall reform agenda was too ambitious and many of the stakeholders were involved

in numerous consultation processes about various trust applications and community service mergers across the region, beyond the local community. Several interviewees felt this was a time consuming process and a non-productive use of their time.

### ***Ontario Case***

In the Ontario case power was delegated by the provincial government to the community. The government wanted to operate at arms length during the review and restructuring process and this was supported by Bill 26 which in effect separated politics from decision-making through the appointment of independent bodies to take the change process forward. The HSRC was appointed at the provincial level to look to the local communities for recommendations for service change. At the local (municipal) level the Hamilton DHC appointed an independent task force, the HATF, to make recommendations. The provincial government was not interested in micro managing service level change and expected the local communities to lead on this initiative. The key to this approach was that (a) the HATF was a community-based group that was truly (and not merely nominally) independent, and composed of local people with experience relevant to health services but with no personal involvement in the stakeholder organisations, (b) the HATF was empowered by the DHC to evaluate and plan local health care services and (c) it was the responsibility of the stakeholders to review the recommendations put forward by the HATF and report back to them.

In conjunction with the HATF service review, the hospital boards of HCH and CMH were evaluating whether to proceed with a merger between them. The most important aspect of this consultation process was that stakeholder feedback and dialogue were a formal and integral part of the process. Stakeholders' input was expected, valued and taken into account by both the HATF and later by the HSRC.

The stakeholders were able to unite in opposition to the final HATF report and the recommendation to close SJH was not followed by the DHC. At the same time, the decision to merge CMH and HCH was initiated by the stakeholders and supported by the community as a viable alternative to the hospital closure proposed by the HATF. This may still not have been sufficient to satisfy the HSRC, which in the course of its review met with the hospital and key stakeholder groups and, after considering their

reports, decided to take several of their recommendations on board in its final report. Prior to its final report, the HSRC granted the hospitals' request for a 30 day extension to the submission deadline. This shows that the change process was stakeholder-driven, in collaboration with the independent review bodies, and that each party was clear about its role and tasks.

In marked contrast to the English case, consultations related specifically to services and stakeholders in the local community. The stakeholders were subjected to only two consultations: first, by the HATF concerning system and service changes across the local health care community and second, by the HSRC regarding the final distribution and allocation of hospital services in Hamilton, including the new HHSC. Stakeholders were not expected to participate in consultations concerning services outside their local community. Their roles and boundaries were thus more clearly defined than in the English case.

### ***Hospital Restructuring***

The differing approaches seen in the cases during the consultation period continued into the hospital restructuring phase. In the English case the hospital CEO, with the support of the RHA, continued to dominate the reconfiguration of the RVI following the absorption of NGH's services and assets. The senior and upper management of this hospital remained intact and the only changes that took place were from the middle management level of the organisation down. A new model of service delivery was introduced through the clinical directorate system. The main focus of change in the hospital was the integration of clinical services from the NGH.

In the Ontario case there was evidence of a continuous commitment to stakeholder co-operation in the post-merger restructuring phase. This had begun earlier, with the creation of the Merger Transition Committee, and continued with the appointment of the new HHSC Board and senior management team, even down to the appointment of Clinical Directors. There was always an effort made to have equal representation from both merged hospitals.

#### **8.4. Power and the Role of Stakeholders**

In this study, the researcher found that certain tactics and stakeholder affiliations strengthened the power base of key actors during the change process in both the consultation phase and the post-merger restructuring phase. Strategic alliances and collaborations were successful tactics used in the stakeholder-led approach to increase stakeholders' power positions. Sharing the hospital site with the local University proved to be advantageous for stakeholders in both cases. The contrasting roles of a powerful CEO or hospital board also had different outcomes in the cases and are discussed in relation to the power dynamics in both approaches.

##### ***Strategic Alliances and Collaborations between Stakeholders***

The stakeholder-led approach featured strategic alliances and collaborative efforts throughout the Ontario case. The alliances and collaborations were used defensively, and for different purposes. The alliance between HCH and SJH, and the merger between CMH and HCH, were both used as a tactic to contain costs, reduce service duplication and more importantly, avoid hospital closure. The collaborations were primarily defined in terms of group power and political allegiance to a cause. The AHCN had the support of key organisations across the local health care community and as a powerful coalition; this group's intention was to persuade other groups and gain community co-operation and solidarity. Through their collective power, they were successful in overturning the recommendations to close two hospitals (SJH and St. Peter's) in Hamilton. The Medical Advisory Committee, which had the support of medical groups within both HCH and CMH, used a similar tactic. Their goal was to be first at the finish line by drafting professional by-laws before the new hospital became official, and in that way they were able to preserve their autonomy and make sure certain practice and medical service demands would be met. Their approach was a professional allegiance and collaboration that ensured the medical professionals across sites had a voice in the new hospital.

The British government-led approach contrasts starkly with the Canadian approach. There was no collaboration between stakeholder groups or any co-ordinated effort across the community. Stakeholders tended to act independently. This isolated and fragmented approach weakened the power position of the community and played into

the hands of the RVI and Freeman hospitals. There was no evidence that the community was stopped from working together even though it was clear that the DHA did not encourage the community to come up with a community based solution and did not want to deal with any collective opposition. The only evidence of any collaboration was the essentially aggressive alliance formed between the RVI and the Freeman during their secret talks with the RHA prior to the announcement of the ASR. Even the medical doctors in this case did not collaborate and acted in a parochial manner. Their action can be regarded as institutional allegiance as opposed to the professional allegiance seen in the stakeholder-led approach.

### ***The University Link***

The university in both cases was perceived as a powerful stakeholder, instrumental in influencing the hospital merger or closure outcomes. It was found that where a hospital was located on the same site as the local University medical school, this association gave the hospital a perceived advantage over the other hospitals in the form of more political leverage during the review process. Neither the RVI nor the McMaster Hospital site of CMH was targeted for closure at any stage, whilst all the other hospitals were at some stage considered for possible closure or downsizing.

### ***The Hospital Board and the Role of the CEO***

The CEO in the government-led approach was allowed to dominate the restructuring process, while the hospital board led the merger process in the stakeholder-led approach. The CEO of the RVI took an adversarial stance with regard to NGH both at the Seaburn Workshop and also during the restructuring of the new RVI. The CEO's power and position was never challenged or opposed nor did he appear to compromise on any major decision. The RVI was clearly the "winner" in this restructuring saga and the NGH was the loser. The RVI survived closure, remained the largest and most powerful hospital in Newcastle, inherited most of the NGH's clinical services, received a substantial proportion of the NGH's assets, and secured additional service funding.

In the stakeholder-led approach, the decision to take the merger proposal forward was taken at the board level. The alliance agreement between HCH and SJH was negotiated by the CEOs. When the CEO of CMH declined to join the alliance of HCH and SJH for inappropriate reasons, the CEO was viewed by the board as an obstacle to change and it was decided jointly by the two boards to sideline the CEOs from the merger decision-making process altogether. The merger transition committee was formed with equal representation from both hospital boards. This group led the merger process and directed the form of the new merged hospital, starting with the creation of a new constitution and board.

### **8.5. Government Manipulation of Process**

The British government through the RHA manipulated the whole review process by conducting secret talks with the RVI and Freeman Hospitals for four months before launching the ASR. This led to the “Larry” document drafted by the CEOs of the RVI and the Freeman recommending closure of the NGH. The RHA also gave the RVI sensitive information regarding NGH’s intention to re-apply for trust status, and denied NGH trust status twice even though NGH fulfilled the usual requirements for such status.

The British government was single-minded in its approach to restructuring and appears not to have been concerned with what the community wanted. The closure of NGH was determined from the outset. This was evident in the early stages of the Acute Services Review when the government recommended that the RVI merge with Hexham General Hospital and again at the end of the ASR when the Secretary of State rejected the CHC’s appeal against the decision to close NGH and simultaneously announced the creation of the new City Trust on the NGH site. The stakeholders in the English case had no significant input into the merger/closure decision, and the RVI and Freeman Hospitals as “winners” can be regarded as having been powerful simply by reason of being favoured by the State.

A number of stakeholders and actors accused the government of withholding vital information regarding the restructuring proposals, and some of the information that

was provided was incorrect and misleading. Readily available, accurate and up to date information is vital if key actors are to make informed decisions.

In contrast, in the Ontario case the HATF and the HSRC made sure that detailed information was available to the stakeholders and local community. Government reports, tables, service figures, detailed costing with sources and methodology information was included in full or fully referenced. The Task Force and Committee membership, roles and contact details were published as well.

### **8.6. Theoretical Review: Archetype Theory and Fligstein's Approach Re-visited**

After reviewing archetype theory and Fligstein's work on power and the role of actors (see Chapters 2 and 7), it was decided that the best way to approach hospital mergers would be by combining both of these theoretical viewpoints. Archetype theory provided a framework which allowed the researcher to analyse the pattern of development seen in the cases and to assess whether a new type of hospital had emerged, and whether it could also be considered a new and effective organisational pattern (an "archetype", to use the concept from the theory). This new organisational form would be evaluated in terms of the extent to which it comprised a new organisational structure, systems and underlying values. Hinings and Greenwood's (1988) use of organisational tracks would provide a structure for mapping and analysing sequential events during the merger transition period. It was found that in the Ontario case the evidence pointed in the direction of real archetypal change whereas in the English case, there had been no attempt to move from one hospital archetype to another. The RVI and Freeman had already, albeit recently, made the transition to the newly created NHS Trust Hospital archetype and their acquisition of the NGH services and assets did not change the interpretive scheme underlying their existing Trust status.

Archetype theory provides a useful framework for assessing the direction and scale of change, and suggests that change to a new organisational form will be effective when there is agreement at the level of values concerning the adoption of the new organisational form. To this extent the analysis here has been assisted by the



conceptual framework provided by archetype theory. However, a potential weakness of archetype theory in the context of public sector hospitals in Britain arises from the fact that much of the theory is rooted in the research done by Greenwood and Hinings (1993) in the municipal government sector in England and Wales in the early 1970s. One of the criteria underlying the choice of that sector as the research milieu was that local authorities had discretion to organise as they wished, thus avoiding the problem of constraint by parent companies. This criterion does not apply to the public sector hospital organisation. Before the Trust reforms of 1991 such hospitals were directly managed by government agencies. After those reforms, hospitals with Trust status had to be organised as prescribed by the applicable regulations.

Further, archetype theory is judged to be inadequate in the explanation of the *causes of change* and the *likelihood* of successful adoption of an effective new form. Fligstein's perspective on power and his emphasis on the way key actors use power and social skill to influence and control or induce co-operation in other actors, are considered by the researcher to be key to understanding the outcome of change in both these cases. Fligstein's work was therefore used to fill the perceived gaps in archetype theory.

### ***Archetype Theory***

The stakeholder-led approach to hospital change supported several aspects of archetype theory. This approach followed a transformational track of change and a new hospital archetype, the multi-site networked organisation emerged. The change in the hospital structure and the adoption of new systems and models of service delivery, together with a definite shift in values can be seen as the new hospital emerges. The structure of the hospital changed all the way from the top (Board level) down to frontline service delivery. The hospital adopted a more entrepreneurial approach to doing business, with the development of numerous new management and collaboration contracts, academic partnerships, formal affiliation arrangements and international service level agreements.

In the government-led approach, by contrast, there was no evidence of transformational change in the system but more importantly no attempt to change the

type of the merged hospital (the new RVI) following its acquisition of services and assets from another hospital. Thus this important public sector change scenario was not well addressed by archetype theory. None of the theory's tracks of change, all of which assume some attempt at least at transformational change, could be applied to the change process here. It was concluded that there had only been structural adjustments to the existing hospital structure and this was done primarily because of the need to integrate additional clinical services that were being transferred from another hospital site, without any change in the underlying values and outlooks of the participants. There were no changes in the composition or structure of the board or senior management team, suggesting that the existing team and their beliefs and values were not in need of change. The same groups of actors remained in their respective positions of leadership and power throughout the entire change process. The underlying values of the hospital did not change from the shift that had already recently taken place with the introduction of Trust status for the hospital sector. It was considered that with its expanded middle management structure and additional clinical services inherited from the NGH, the new RVI hospital organisation could be described as a structurally adjusted or evolved Trust hospital.

Prior to the study, there were reservations about the theoretical notions in archetype theory of structural coherence and organisational stability. When examining the outcome of the stakeholder-led approach and in particular the emergence of a new hospital archetype, the organisational coherence that had been a major goal of the merging hospitals appears to have been achieved.

It is more difficult to assess the degree of organisational stability achieved, although as noted at the end of Chapter 6, despite continuing financial and other problems in the sector, Hamilton still has its four acute hospital sites, with a configuration of programs and services substantially as approved by the HSRC in 1998 and this would indicate a degree of stability within the overall organisational field comprising Hamilton's acute hospitals.

The new hospitals in both cases were beset by problems caused by financial mismanagement by the government, which led to varying degrees of organisational instability. This is a very serious finding because it happened in both cases and does

not appear to be linked to the approach taken to the merger or the organisational outcome. In the cases studied here, both the English and Ontario governments seriously miscalculated the costs and associated expenses of the hospital mergers, restructuring tasks and the clinical re-configuration and cross site integration. Both governments projected substantial savings by merging, closing and restructuring of health care services. However, the mergers' costs exceeded the projected savings because of site-redevelopment costs, transfer of acute services across sites, staffing redundancies and severance packages, unexpected wage increases and lost revenue from the disruption of the program re-design and restructuring. The hospitals also experienced problems around delivering patient care because of the costs, beds were closed, wards were shut, operations were cancelled and waiting list began to develop.

A startling revelation was that both the DOH in Britain and the provincial government in Canada defaulted on payment of money promised to assist the hospitals with their additional restructuring costs. The British government promised to give the RVI £63m to help cover its costs, but half way through the restructuring informed the hospital that it would now only contribute £30m. The RVI was only able to avoid bankruptcy by financing some of the restructuring projects through the PFI scheme. In the Ontario case, the government promised HHSC additional funds to assist with the restructuring and other unanticipated costs at the time of the merger in 1996 but such payment was not forthcoming until 1999. By this time, HHSC had a substantial (and record breaking) debt of \$38m. The money that finally arrived was not enough to pay off this debt but only provided temporary relief. These are important findings in both cases and whilst it is difficult to determine if the default in payment was solely responsible for the financial problems experienced, it cannot be ruled out as at least a significant contributor to the debt. Thus organisational stability in the public sector, to the extent that it depends upon adequate financial support, is a factor that is not within the control of the organisation itself. The theoretical concept of organisational stability may therefore be of limited value in studies of public sector organisations.

### ***Fligstein : Power, Government and Stakeholders***

Fligstein's work on the role of power and the ways in which the state and key stakeholder groups use power and social skill to influence and induce co-operation in

other actors and drive change, inspired the researcher to look for similar patterns in the health care field. The researcher considered that Fligstein's approach addressed areas that were underdeveloped in archetype theory.

The main focus of this research is on power. The two main questions were: 'who had the power in the cases' and 'how was this power used'? This research revealed that the change or merger process was either government-led or stakeholder-led. The study identified, described and analysed the behaviour of the government in relation to stakeholders, the behaviour and interaction between stakeholders, and which stakeholder groups or actors were powerful.

The results of the study indicate that the access to information was an important requirement for power. The withholding or sharing of information had an impact on the stakeholders, who could be either misled or appropriately informed about certain government actions. Several different power tactics were used by both the government and stakeholders and these actions had different outcomes depending on whether the change process was government or stakeholder-led. In the stakeholder-led approach, stakeholders strengthen their power position in relation to other stakeholder groups or a powerful actor used strategic alliances. In the government-led approach this tactic was used to weaken the political position of another actor. Collaboration was a tactic used only in the stakeholder-led approach. This was an effective tactic employed by stakeholders across the local health care community. It gave them the collective power to persuade the DHC and subsequently the HSRC to drop proposals for hospital closures. Stakeholders in both approaches found it was to their advantage to either partner or align themselves with a stakeholder who was at least if not more powerful than themselves. This decision would not just strengthen their power position but saved them both from any threat of closure.

The alliances, allegiances and collaborations in the Ontario case are good examples of what Fligstein calls "social skill", the ability of actors to use rules and resources skilfully so as to induce co-operation in others. A further example to be found in this case was the successful effort of the community, led in this instance by HHSC, to come up with a new role for St. Peter's Hospital that contribute to the HSRC's goal of an integrated health care system and save that hospital from closure. Had the

community not come up with this plan on its own initiative, the HSRC would have closed St. Peter's. In the English case, social skill was manifested in the form of the tactics used by the RHA to appear not to be directly involved in the closure of an acute hospital (NGH), to control the agenda behind-the-scenes, and to covertly coerce opponents into co-operation. These tactics were primarily of three kinds: getting people to think that it was the RVI and Freeman that were in control of the reform process; setting the agenda; and isolating NGH and other opponents to the RHA's plans.

There were two kinds of power in this study which played a major role in moving the merger and restructuring process forward. In the government-led approach, power was concentrated at the actor or leadership level of the hospital, under the authority of the RHA. In the stakeholder-led approach power was dispersed between the stakeholders, and within the merging hospitals themselves the Boards removed power from the hands of the CEO as this would have hindered co-operation with the other merging hospital. Overall, there were many parallels between this study and Fligstein's work and conclusions. Fligstein's theory that organisational change is financially motivated, politically led and manipulated by the state and other powerful actors is well supported by both cases, the difference ultimately lying in the way in which the State in one case retained and exercised its power to privilege its favoured actors and in the other case delegated its power to the community stakeholders and independent local and provincial review bodies.

### **8.7. Factors Influencing the Success of the Merger Process and Outcome**

The researcher found that common themes began to emerge from stakeholder feedback about how best to survive and succeed at merging hospitals. These organisational factors are important and failure to consider these issues could affect the outcome and prevent any merger achieving its full potential. The organisational success factors identified are: leadership, change management, vision, human resources, organisational culture and structure.

## *Leadership*

The most critical factor in implementing successful organisational change is the senior leadership team. This team needs to be objective, comprehensive and highly disciplined in assessing, planning for, and managing organisational change. Successful leadership calls for a willingness to grasp the complexity and ambiguity of public sector change. Effective leadership also demands a capacity to be politically astute, address the concerns of external stakeholder groups and the ability to serve as a champion of change. Change always engenders resistance because it threatens the status quo and introduces uncertainty. Senior leaders must therefore be willing to drive the change process forward, complete the merger deal and realign the new organisation. Where a senior leader such as the CEO is resistant to change, the Board or other body to which the CEO is accountable must be willing to step in and take over the merger negotiations.

## *Change Management*

Successful change management is a long-term process. Being effective is a function of creating a mindset, attitude and skilfulness at managing change. Merger objectives need to be clear so the change process can be strategically planned and progress can be accurately measured. It is important to learn how to pace change. It should be a staged process with clear tasks and supported by staff with the least disruption to patients. If change is too slow it will be painful, and if it is too fast staff become overwhelmed, de-motivated and stressed. Time scales should be carefully mapped out, with realistic targets and completion dates. In successful merger scenarios, organisations use transition mechanisms to address implementation issues on an ongoing basis. These mechanisms include an integration team, a cross-functional transition team and a senior executive and Board committee. Political judgement and tactics are important for manoeuvring and manipulating the process. When bringing organisations together, it is a good philosophy to build on their mutual strengths and work together on weaknesses.

## *Vision*

Organisations require a sense of direction or vision for practical purposes such as guiding resource allocation decisions, and giving people a sense of purpose. When a hospital is acquired in a hostile take-over, almost all sense of identity and direction will be lost. Yet for the strong acquirer, the transaction may represent an affirmation of the hospital's vision and direction. The uncertainties of the transaction require that the original vision be clarified or significantly reformulated to galvanise the new organisation. When two organisations are merged, the new vision must clearly articulate the goals of the combined entity which will provide a focus, logic and rallying point. If the vision is to have value, it must be communicated to all employees and must be backed by persuasive senior management action.

## *Human Resource Focus*

Understanding and managing people and helping them adjust to the transition is vital for merger success. Hospital employees will experience considerable anxiety as they are bombarded by information from inside and outside the hospital. The timeliness and accuracy of this information can be difficult to evaluate. As a result, staff feel both uninformed and unimportant, and this leads to unproductive behaviour and increases in absenteeism. Senior management need to make regular communication a high priority. In addition to communication efforts, the merger management processes must involve as many employees as possible in identifying integration issues. People respond much better when they are allowed to have input into the transition process.

## *Organisational Culture*

Understanding the nature of organisational culture and its contribution to management processes and the work environment is critical. Culture is shaped over long periods of time and can be relatively difficult to change, and mergers are usually overshadowed by previous organisational relationships. It is important to acknowledge that different cultures exist in organisations and these issues need to be addressed. Therefore it is important to build a new organisational identity that staff can align themselves with and move on from identifying with their old institution. Developing a new

organisation entails more than just changing the organisation's name. The new organisation needs to be developed slowly and deliberately by establishing common goals and drivers over time.

### ***Developing a New Organisational Structure***

During the transition period collaboration is important and decisions should be made in a timely manner. The new Board needs to come together and provide direction for the new organisation. It is important to have the doctors' support if any change program is to be successful. The co-locating of people from the different organisations is one of the simplest but strongest techniques for developing common purpose and process. Where people are located delivers powerful messages about the scope of their job and how much the hospital values the actual integration of the two organisations. Organisational restructuring and change are complex and costly. Budgets can never be overestimated. A key skill in implementing organisational restructuring is to learn how to manage chaos.

### **8.8. Limitations and Suggestion for Further Research**

These findings of this research must be seen as limited to the two cases studied, and in order to determine whether a stakeholder-led merger and restructuring process is more likely to result in a new hospital archetype than government-led one, further case studies are needed. It should be recognised that in the English case the government was working within the relatively new internal market model of health care provision, and the RHA approached its Acute Services Review from the standpoint of a purchaser of services:

“The health authority has a formal role, under current national guidelines, to lead public consultation on major changes to local services but our prime task is to agree a strategy for the purchase of future services. An authority decision on the best way forward will represent a new purchasing strategy, setting a clear framework within which NHS Trusts and other providers will work”. [150:1]

There was no concern here with organisational culture or form.



In sharp contrast, the Health Services Restructuring Commission in the Ontario case was more concerned with the need to integrate health services across the system and recognised that:

“Organisations possess distinct cultures and may have different approaches to the delivery of health care services. Integrating services requires fostering new cultures, appreciating organisational histories, and nurturing the positive attributes of each organisation. It is imperative that traditions of excellence be retained in the cultures of newly formed organisations.”

[129:4]

With the recent move away from the internal market model in the British NHS, further studies of more recent English and Ontario hospital merger cases should, the researcher believes, provide further insight into the relationship between the roles and influence of government and stakeholders and the likelihood of organisational transformation. In addition, the following areas for further investigation are suggested as relevant:

1. What types of communication strategies win support for a merger from the staff and the community?
2. What is the definition of culture in the context of public sector health services organisations?
3. What is the process of cultural change and what mechanisms facilitate the stabilisation of a new culture in a merger?
4. Are the issues for micro mergers of departments and programs within a hospital the same as for the main hospital merger?

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## Document Reference List

Doc. No.	Date	English Case: Document References
1	00/04/1991	Royal Victoria Infirmary and Dental Hospital, Newcastle Upon Tyne (April, 1991) <i>Application for Trust Status</i> .
3a	00/12/1992	JB Wilsdon, Consultant Radiologist (December, 1992) Letter to the Health Service Journal entitled 'Clearing The Fog'.
3b	00/12/1992	Health Services Journal (December, 1992) News item: 'Hospital unveils plan to fight off take-over'.
3c	00/11/1992	Evening Chronicle (26 <sup>th</sup> November, 1992) '150 years of caring: General under threat: Respected teaching hospital'.
3d	26/11/1992	Evening Chronicle (26 <sup>th</sup> November, 1992) 'General faces huge cutbacks: Secret report reveals shock takeover plan by RVI and the Freeman'.
3e	26/11/1992	Jim Cousins, MP, Newcastle Upon Tyne Central (26 <sup>th</sup> November, 1992) Press Release: 'Newcastle Hospitals Civil War Breaks Out'.
3f	01/12/1992	Jim Cousins, MP, Newcastle Upon Tyne Central (1 <sup>st</sup> December, 1992) Press Release: 'Newcastle NHS Trusts Creating A Monopoly Says MP'.
4	09/12/1992	Hospital Services Planning Group, Newcastle General Hospital (9 <sup>th</sup> December, 1992) <i>Newcastle Hospitals Configuration</i> .
12	00/00/1996	Tynedale Total Fund (1996) <i>Open Yellow Book: New Horizons for Healthcare in Tynedale</i> .
20a	09/12/1993	Parliamentary Under Secretary of State (9 <sup>th</sup> December, 1993) Letter to the Chairman of the Newcastle Community Health Council regarding 'The Future of Health Care in Newcastle'.
35c	10/11/1995	The Royal Victoria Infirmary and Associated Hospitals NHS Trust (10 <sup>th</sup> November, 1995) Minutes of the Trust Executive Group.
57d	21/06/95	The Royal Victoria Infirmary and Associated Hospitals NHS Trust (21 <sup>st</sup> June, 1995) Trust Board Minutes (Agenda Item 3.5) <i>Project Management Update, Director of Personnel</i> .
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