

First-Line Nurse Managers' Challenges at the Crossroads of Norwegian Health Care Reforms

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Norwegian municipal health care has large public service offerings, funded by tax revenues; however, the current Norwegian welfare model is not perceived as sustainable and future-oriented. First-line nurse managers in Norwegian municipal health care are challenged by changes due to major political and government-initiated reforms requiring expanded utilization of home nursing. The aim of this theoretical study was to describe challenges the first-line nurse managers in a Nordic welfare country have encountered on the basis of government-initiated reforms and to describe strategies to maintain their responsibilities in nursing care. First-line nurse managers' competence, clinical presence, and support from superiors were identified as prerequisites to maintain sight of the patients in leadership when reforms are implemented. The strategies first-line nurse managers in Norwegian municipal health care use to implement multiple reforms, regulations, and new acts require solid competencies in nursing, leadership, and administration. Competence in nursing enables focus on the patient while leading the staff. Supports from superiors and formal leadership networks are described as prerequisites for managing the challenges posed by change and to persist in leadership positions. **Key words:** *caring, caritative leadership, municipal health care, Norway, nursing leadership, reforms*

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NORWAY IS considered a comprehensive welfare state with an emphasis on universal and generous social security schemes that include a high degree of financial compensation in case of loss of income due to illness, disability, or old age. It has large public service offerings that are funded by tax revenues, especially in health care and education; however, the current Norwegian welfare model is not perceived as sustainable and future-oriented because of the way it is organized. Elderly people with extended care needs and people with mental disorders are rapidly growing patient groups in Norway.¹ Through reforms, the Norwegian government seeks to secure a future health care service that responds to the patient's need for coordinated services and helps with major

socioeconomic challenges. Equal access to good health care services, regardless of personal finances or domicile, will continue to be the most important cornerstone of the Norwegian welfare model. These challenges to the health care system have significance for the patients, nursing care staff, and health care organizations, which have subsequently started bringing nurses as first-line nurse managers (FLNMs) and caregivers to a crossroads.

This theoretical study explores FLNMs' perspectives on Norwegian municipal health care services, describing the challenges FLNMs are facing due to reforms initiated by the government in a Nordic welfare state. We also describe and discuss strategies to maintain their responsibilities in patient care in this context. The Norwegian perspective in this article is based on our studies²⁻⁷ in the context of Nordic municipal health care (Norway, Sweden, and Finland) with similar welfare models.

THE NORWEGIAN HEALTH CARE SYSTEM: A NORDIC WELFARE MODEL

Norway's population is increasing and has reached 5 345 599 inhabitants.⁸ In 2017, the life expectancy was 84.3 years for Norwegian women and 80.9 years for men and has continued to increase steadily. According to the Institute of Public Health, 4 major groups of diseases cause most of the premature deaths in Norway: cancer, cardiovascular diseases, chronic lung diseases, and diabetes. The ambitious national goals are to become one of the top 3 countries in the world with the highest life expectancy; to have a population that experiences several years of good quality of life, well-being, and minimal social differences in health; and to create a society that promotes health in the whole population.⁹

Norway has a government-controlled health care system that is financed through the tax system, which is mainly owned, organized, and managed by the public sector.¹⁰ Every citizen has access to health care based on the individual's needs, regardless of age, gender, social status, or economic situation.¹¹ Norwegian citizens may also choose to use pri-

vate health care that they pay for themselves. Private health care services are considered supplemental to public services, such as general practitioners, dentists, physical therapy, mental health care, substance abuse, rehabilitation, and diagnostics. About 5% of the cost of specialist health care is related to private, nonprofit, and commercial organizations. Today, 10% of nursing home services are provided by private organizations, equally offered by nonprofit and commercial organizations; however, private home care services are not as widespread as private services and are mainly available in urban areas.¹² Overall, Norwegian health care is perceived as well functioning, with an emphasis on evidence-based medicine and health care and the latest medical technology to enable patients to maintain their quality of life and independence.⁹

Municipal health care in Norway

Municipal health care is a relatively young service from a historical perspective; the following describes its milestones in development. Municipal health care was hardly mentioned in public health care studies until the 1970s. Initially, there was a lack of national organized health care; the services varied across the different municipalities and functioned more as a practical and social assistant service. In 1982, home services were regulated as a municipal health service through the Municipal Health Service Act. The ideological transition from institutional care to home-based care took place in 1992, which became the prelude to the comprehensive development of the home care services that we now know as the mainstay of the Norwegian municipal health care service. A framework founding for the municipality was introduced, and the responsibility for nursing homes was transferred from the state to the municipalities in 1998. The municipalities were given the responsibility to prioritize between the different services provided.^{13,14} This development was intended to give municipalities greater freedom to organize themselves as they found beneficial based on local variations.

The public health care services are organized on several levels, where municipal health care belongs to the basic level and is seen as the fundamental part of the Norwegian welfare model. The second level is specialist care: local, regional, and national hospitals for somatic and psychiatric treatment. The third level is university hospitals. All 3 levels are paid through the tax system. Overall, more people are employed in municipal health care than specialist health care.¹⁵

Today, municipal health care services are complex and include a variety of different services: general practitioners, medical emergency wards, school health clinics, clinics for children and teenagers run by public health nurses, obstetric and neonatal follow-up clinics run by midwives, rehabilitation, psychiatric care for adults, institutional care for elderly people, and home care services provided in patient homes. However, health care staff in municipal services consult and forward the patient to the specialist level when the patient's health requires more or different kinds of competence than they can provide.

Norway is a land with great distances between settlements, and the population is widespread. Therefore, municipal health care is organized into 1 or more sectors based on the patient's geographical residence, and each sector has its own leader, staff, and budget.

Government-initiated changes in Norwegian municipal health care

Since Norway has an aging population that faces multiple morbidities—and therefore complex and extended care needs combined with limited economic resources and a shortage of health-educated staff, especially nurses—its welfare model is threatened.^{1,16} An answer to these foreseen challenges is government-initiated reforms and acts combined with a political and financially motivated merger of municipalities. The latest reforms include Coordination Reform, the Healthcare Service Act, the reform named “Living All Your Life,” and the new act for first-line managers. Each of these acts impacts Norwegian municipal health care leadership.

Coordination Reform

One of the largest reforms in Norwegian municipal health care's history—the Coordination Reform—was put into effect in 2012.¹ The reform is based on a New Public Management (NPM) ideology, developed from private business, in order to increase efficiency and reduce public spending. The primary intention of this reform is to coordinate the health care given in hospitals and municipalities, with the intention of transmitting responsibility for advanced treatment and care away from the hospitals and out to the municipal facilities. At the same time, a shift within the municipalities from institutional care toward the extended use of home care is also a wanted change that emanates from Coordination Reform. It affects and changes the responsibilities between the different levels in the Norwegian health care system, as well as within the basic level of municipal health care.

Even if the historic governmental development and the new reforms toward locally administrated and prioritized municipal health care are wanted, their impact has been diminished because of the detailed state-level management described in laws and requirements.¹⁷ One example is the patient safety program named “In Safe Hands,” which has the overall aim to reduce patient harm, build lasting patient safety structures, and improve patient safety. In this program, national health care experts have identified several targeted areas that they instruct the municipalities to focus and report on; for example, fall events and medication reconciliation.¹⁸ This might be an expression of a governmental need for highlighting and securing the quality of patient care.

Consequences of the Coordination Reform seen in municipal health care

The implemented Coordination Reform has coincided with more of elderly people wanting to live in their own homes with assistance rather than moving to institutions with 24-hour continuous care.¹⁹ The number of recipients of Norwegian home care services

increased by about 18% from 2007 to 2017 and increases with age. In 2017, in total, 217 059 people 67 years and older received nursing and care services and about 50% of these lived alone. Now, 2 of 5 patients are men, and every fourth is younger than 50 years, which is mostly due to increasing male life expectancy.²⁰

When evaluating the effect of the reform, it appears that the goal of more comprehensive treatment of patients was not achieved. There is an imbalance between the utilization of knowledge and expertise in specialist health service and the municipalities. Their collaboration is asymmetrical because hospitals define when the patients are ready to be discharged without the municipalities being particularly involved in the decision. Through an economic incentive, the idea was that it would pay off for the municipalities to take home patients as quickly as possible in order to deal with them more affordably. For every patient ready to be discharged, the municipality pays a penalty of 4885 Nkr (US \$489.84) to the hospital for each day they are, for some reason, not taken home.²¹

Because the responsibility for more specialized patient treatment and care is shifted to the municipalities, there is a need for municipalities to increase competencies to manage tasks that were previously solved in hospital care. Several years after the implementation of the Coordination Reform, many municipalities are still unprepared for their new responsibilities and lack sufficient competence and staff to safeguard patient care.²² There is reason to believe that frail elderly patients who are discharged to their own homes are a high-risk group for repeated hospital admissions. A generally increased readmission rate was seen after the introduction of the Coordination Reform, particularly in the acute geriatric population.²³ These patients are given the title “revolving door patient” without recognizing the suffering that these patients and their relatives experience due to frequent relocations and constantly meeting new staff. It is important in nursing leadership to ensure patient safety and caring for these vulnerable patients.

The Healthcare Service Act

An important new governmental act for patient safety for nursing leadership to implement is the Healthcare Service Act. This act²⁴ regulates the obligation to warn the Norwegian Board of Health Supervision about serious health incidents. The act previously regulated only specialist health care, but in July 2019, the act began to regulate warnings about municipal health care services as well. This gives patients and their relatives the opportunity to warn of serious incidents in municipal health, just as hospitals have since 2011.

“Living All Your Life”

Another important reform for responsible nursing leadership, launched in 2018, is named “Living All Your Life.” Previous reforms have often been about systems, whereas this one is about people and is described as a quality reform. With this reform, older people have the opportunity to be masters of their own lives where they live and are shown the benefits of togetherness, activity, good food, and health services as focus areas. Through “Living All Your Life” for the first time, the government has unified and systematized the work of some municipalities that found new and better solutions for providing services to older people. However, many of these solutions are being used by too few municipalities and often unsystematically. Therefore, the services are perceived to be of poor quality and the quality of services for elderly people varies too much and is not acceptable. Along with already-implemented initiatives and measures, through this reform, the government is pursuing a new and sustainable policy that will ensure that all citizens have the help necessary to safely live to a good old age. This means better services as well as a community where elderly people can use their resources.²⁵ Nursing leadership needs to take responsibility for implementing high-quality care.

A new regulation for FLNMs

While these political changes are being implemented, the awareness of the importance

of leadership has been emphasized even more. The requirements and expectations placed upon leaders are highlighted and even tightened by the new reforms. In Norway, emphasizing the responsibility of leaders was taken a step further in 2017 with a new regulation that elaborated the requirements for managers and management systems throughout health and care services. The aim is to contribute to professionally sound services as well as increase the amount of systematic work on quality improvement and patient safety.²⁶

FLNMs in Norwegian municipal health care

Traditionally, FLNMs are nurses and often recruited from the perceived best nurse clinicians¹³; however, there is no automatic correlation between being a skilled nurse and being a good leader. Still, the trend of promoting clinical experts to management continues. Nurses may receive little or no training or support during the transition process from clinicians to managers,²⁷ but this process requires care and tending.²⁸ A correlation has been found between patient outcomes (such as patient satisfaction) and leadership^{29,30} because good leadership results in high-quality care and poor leadership results in poor care.³¹ Recruitment into leadership positions is important for leaders' engagement and consequently quality of care.^{32,33}

The education of nurses in Norway takes place at the university level; all prospective nurses must earn a bachelor's degree in nursing. Norwegian FLNMs seem to be well qualified for their positions: 3 of 4 have supplemental education in leadership, 6 of 10 have continuing education in nursing, and 3 of 10 have a master's degree.^{1,34}

The requirements and expectations for leaders are highlighted in reforms and are now outlined in regulations; however, these legislative acts have not been followed up by any standardized descriptions of the preferred competencies of FLNMs. In job advertisements for first-line manager positions,

the listed required competencies include a bachelor's degree. Applicants with further education in leadership or experience as a leader are preferred, but such education or experience is not considered necessary. Being a nurse or having a bachelor's degree from any health care profession is therefore no longer needed when applying for these positions. Therefore, engineers, economists, and even people without a health care education are now being hired as FLNMs in Norwegian hospitals and municipal facilities. The Norwegian Nurses Association has developed its own political platform with guidelines that describe what characterizes good leadership for nurse leaders,³⁵ but it is only indicative for praxis.

FLNMs work closely with patients and the health care staff, leading and managing care at the unit level. Complex and constantly changing work situations characterize the work environment of FLNMs.³⁶ FLNMs are responsible for implementing new national health care reforms and acts into daily care.³⁷

Leading in the context of municipal health care is leading from a distance because patients live and receive treatment and care in their homes. FLNM meeting points with their staff are in the morning at the office before the staff leave to care for patients and again at the end of the shift when they return. In the meantime, the FLNMs are left alone in the office.

Areas of responsibility

FLNM responsibilities in Norway's municipal health care system are 3-fold: patient care, staff, and finances. Each unit has its own budget and staff that the FLNM is responsible for. FLNMs' workdays are filled with such work tasks as meetings, scheduling, and organizational matters,³⁸ and they are supposed to effectuate and implement new reforms in their units.

The number of employees per FLNM varies, but the number between 30 and 50 persons is most common. The employees have a varied level of education and consist of nurses, assistant nurses, and workers without a health care education.³⁴

THE IMPACT OF CHANGES ON FLNMs AND THE CHALLENGES THESE CHANGES CREATE

Our research interest emanates from a curiosity of how the FLNMs describe and manage these multiple demands in a changing landscape in the context of Norwegian municipal health care systems.

In this theoretical study, we describe from the FLNMs' perspectives the challenges they have encountered on the basis of the government-initiated reforms in a Nordic welfare state. We also describe strategies to maintain their responsibilities in patient care. The Norwegian perspective in this article is based on our quantitative, theoretical, and qualitative studies²⁻⁷ in the context of Nordic municipal health care (Norway, Sweden, and Finland) with similar welfare models.

In our theoretical perspective, administration is linked to caring for the patient whereas the main purpose in leadership is ministering to the patient. Caring for the patients and their relatives, caring for staff, and managing unit finances are therefore seen as mutually dependent activities. The changing and challenging landscape of municipal health care caused by the reforms also affects this entity as a whole because a change, for example, in economics, can impact the patient, staff, and FLNMs. Our theoretical perspective is based on the theory of caritative leadership,^{39,40} which is well established within caring science and originates from research in the Nordic countries.^{32,39-41} The theory originates from Ericsson's theory of caritative caring with the motive of caritas, which is seen as the lasting and altruistic idea of caring.⁴² The Latin word *administrare* is a combination of *ad*, which means "to" in English, and *ministrare*, which means to "supply, deliver, or serve." An administrator is thus one who serves the central figure of the organizational activity, which in this context is nursing care focused on the patient. This theory therefore contrasts with classical leadership theories because of its emphasis on the patients and their needs. Ministering to the patient is the main purpose in caritative leadership and contributes to an existential

awareness of personal and professional meaning to create a more caring environment. As care is connected to administration, caritative leadership aims to foster an organizational culture based on the ethos of caring, providing a deeper meaning to the culture of the entire organization. To provide the best possible care, a caritative leader needs a combination of management and leadership skills, as well as competencies in caring and nursing sciences, with a minimal overlay of bureaucracy.^{39,43,44}

The competencies needed to care for the patient

As the shift toward extended municipal health care services is implemented, it is expected that staff at all levels will face increased competency requirements. Nevertheless, a discussion of educating some nurses to become advanced nurse practitioners⁴⁵ is met with skepticism. Nurses with a PhD degree are rarely seen in Norwegian clinical health care. Education in administration and leadership for FLNMs in Norway is now provided by schools of business, without the perspectives of nursing or caring sciences.

We argue that an education in management and administration is not enough for FLNMs. FLNMs need to understand the vulnerable patients and their needs of care in order to implement good nursing care and coordinate the patients' care from different health care staff.

To gain a better understanding of caring in nursing leadership, we developed a theoretical model using meta-synthesis in which metaphorical rooms and their relations are visualized.⁴ The findings from this study can contribute and give direction to education in nursing leadership because they showed that caring leadership comprises 5 metaphorical, relation-based rooms that require the leader's attention: the patient's room, the staff's room, the superior's room, the leader's secret room, and the lonely room. These rooms are circled by the organizational room. Caring in nursing leadership is understood as a conscious movement between these rooms in the leader's "house of leadership." Movement stops if these rooms are not given equal

attention—symbolizing that caring in leadership stops as well. The movement described in this model needs to be conscious, with an aim and a purpose. Furthermore, this movement is understood as a requirement for caring to take place in leadership.⁴ Implementing competencies from these findings in nursing leadership can help leaders to maintain their focus on the main task, which is ministering to the patient. Therefore, the educational background's effect is known as “the lenses worn” and is what is observed when leaders are clinically present.

Both NPM and top-down management might result in an increased focus on results and maintaining budgets in leadership. This is demanding for nurse leaders, who need to market their professional contributions to patients and even to society, as well as argue why the competencies gained from earning a master's degree matter to patients and patient safety. Hiring FLNMs without competency requirements and knowledge in nursing can be taken as a devaluation of the nursing profession. In addition, patient safety is jeopardized by management that does not understand what is at stake for nursing care. This contrasts with recommendations from the caritative leadership theory and the findings from our studies, which highlight the importance of combining management and administration skills with competencies from nursing and caring sciences.³⁹ Being a nurse requires competencies in observing patients, making decisions, and leading nursing care, including theoretical competencies in nursing and the caring sciences. Nurses are therefore the natural and necessary leaders in today's health service.^{35,46}

Clinical presence enables safeguarding the patient

Because of an increased emphasis and demands on the FLNMs' responsibility for the quality of care, clinical presence was considered a necessity to meet these requirements.⁴ It is challenging to separate and describe the difference between being clinically present as a nurse or as a leader. Our study contributes

to an understanding of the meaning and purpose of clinical presence from the FLNM perspective as they serve purposes other than engaging in daily nursing activities to alleviate nursing shortages or save the economy.⁷

Our findings show that FLNMs' clinical presence serves the purpose of taking the overall responsibility for care in their units and thereby safeguarding the patients.⁷ When clinically present, FLNMs describe an opportunity to secure patients' voices, build and maintain trust-based relations with their staff, and ensure that the unit's financial consumption is reasonable. Because they are nurses, these FLNMs are able to identify and prevent adverse events and suffering related to care. Although the overall responsibility for the quality of care and finances was described as overwhelming and time-consuming, being clinically present was considered important and therefore a priority in their leadership in order to safeguard the patients.⁷

Support from superiors is a prerequisite to persisting in FLNM positions in this changing landscape

Being an FLNM is emphasized as a demanding and lonely position when implementing reforms, safeguarding staff, and maintaining the primary focus of leadership, which is ministering to the patient. Even if we see a shift toward more relation-based managerial models, the FLNMs still describe a varied degree of top-down management characterized by a command-and-control type of communication and leadership. Participants in all our focus groups⁷ described their organizations as hierarchical, with communication lines extending mainly from the organization and the superior leader to themselves, with a few differences within the same focus group seen. Because of not being listened to and not having their opinions taken into consideration, the FLNMs describe their role as one of personal suffering and loneliness in leadership. Experiencing this one-way communication does not seem to be related to age or experience as a leader in our study but more as an individual feeling.

All the FLNMs stated a wish and a need for relations with their superior to be characterized by trust, personal support, and 2-way dialogue in order for them to manage the changes caused by the new reforms.⁷ They describe themselves as constituting an informal network of other FLNMs for mutual support; however, the FLNMs participating in formal, established, and continuously arranged leadership networks felt empowered and supported. When FLNMs gain confidence in leadership, they extend the way they see themselves as a part of a broader perspective, especially from the perspective of the patients and their families, which is understood as a bottom-up perspective.^{27,47}

CONCLUSION

As described, FLNMs and leaders in the Norwegian municipal health services face increasing demands created by the implementation of the new government reforms requiring expanded utilization of home nursing services. The reforms are understood as top-down reforms, because they are initiated by the government and not by the leaders themselves. First-line management is the managerial level that is responsible and crucial for success when implementing reforms. Putting the reforms into action therefore requires solid nursing leadership skills to meet the many challenges in their organizations and also balance the multiple demands on the services for the good of the patients and staff. Nursing leaders have a unique perspective for developing and enhancing nursing care; however, support from superiors is highlighted as a prerequisite to persist in FLNM positions in this changing and demanding landscape. In addition, it is necessary that leaders offer a clinical presence to verify that staff are provid-

ing the best care possible and ministering to the patients; leaders describe themselves as metaphorical shields to protect patient care.

IMPLICATIONS

Several large reforms require changes in FLNM positions as the findings from the Nordic welfare model have shown. Similar challenges are encountered by FLNMs in the changing landscape of municipal health care all over the world. To meet these described challenges, FLNM expertise should comprise nursing leadership, nursing and caring sciences, evidence-based practice combined with administrative expertise, and the ability to provide the best possible care when ministering to the patients in this challenging environment of Norwegian municipal health care.

The nurse leaders need to market their professional contributions to both patients and society, argue why competencies gained from a master's degree matter to patients and patient safety, and why they cannot be easily replaced by other professions, such as engineers and economists, which is an ongoing discussion in Norway. Opening up the FLNM position to other professions in leadership can be understood as a devaluing of nursing as a profession—or as a way of compensating for the lack of educated nurses overall. Thus, this might be a consequence of nurses not having made their professional competencies visible.

Supports from superiors and continuous, formal leadership networks are described as prerequisites for managing the challenges posed by the reforms. Caring and nursing sciences are in continuous development to improve patient care. Without this scientific basis for a shared direction or vision, the development will be person related.

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