HELSINGIN KAUPPAKORKEAKOULU
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Stakeholder Perceptions of Strategic Changes at HUS

Lotta Kukkula, Szilard Mihalydeak, Juha Pulliainen, Markus Sormaala, Henri Unonius

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MBA Business Project Report

Lotta Kukkula, Szilard Mihalydeak, Juha Pulliainen, Markus Sormaala, Henri Unonius
Helsinki School of Economics Executive Education

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Abstract

The purpose of this research was to explore the stakeholder perceptions of strategy execution at Hospital District of Helsinki and Uusimaa (HUS) in 2007 – 2009. The primary objective was to verify which factors have had the main inhibitory impact on the overall acceptability of the strategy during the strategy process. Furthermore, the research aimed at identification of future success factors to reach the required strategy acceptance among key stakeholders. Research data was collected in a telephone survey for HUS personnel and semi-structured interviews for other key stakeholders. The data was analyzed in a framework of stakeholder theory and change management. In addition, the special characteristics of Finnish health care sector, strong professions and political governance model were taken into account.

According to the research findings the strategy of HUS failed in 2008 due to challenges in several factors affecting the stakeholder acceptability. The strategy acceptance was compromised due to challenges in the areas of capability to change, effects on stakeholders' positions, influencing possibilities, goal clarity, change complexity, management capability, and pace of change. The success of future strategies at HUS will require ability to attract a sufficient level of strategy acceptance from the multiple stakeholders. The crucial success factors include respect to the prevailing organizational culture, active stakeholder management and partnership with primary health care, demonstration of reforming real strategic choices, integration of the overall strategy to execution of operational level strategies, dialogue matching the stakeholder needs and empowering the middle management, and considerate adjustments to the pace of change as may be needed in case of challenges in the identified success factors.

Contents

1 Introduction

1.1 Project background and purpose

This document constitutes a final report of an MBA business project conducted by a research group of MBA students at Helsinki School of Economics (HSE) in 2009. The research group of 5 graduate students participated in the HSE MBA Program in 2008 - 2009. All the research group members are active in working life within various industries such as banking, technical trading, telecom and IT. In addition, one of the research group members has been working for the Hospital District of Helsinki and Uusimaa (HUS) since 2004. The educational backgrounds of the research group members include social sciences, statistics, information technology, engineering and medicine. In the MBA program all the research group members majored in the field of global management.

The business project work is mandatory for MBA graduation. The project is a way of integrating and demonstrating the learning from the MBA program for the benefit of a studied organization. The research group wanted to work on a project with strategic significance for the organization and the whole sector. Health care organizations are facing an increasing pressure to adopt new strategies as the operating environment changes. Redefinition of strategies and ability to change is called for. As a largest hospital district in Finland, HUS is expected to be one of the forerunners in strategic management of Finnish health care. Therefore the research group opted for a case example of HUS in health care sector.

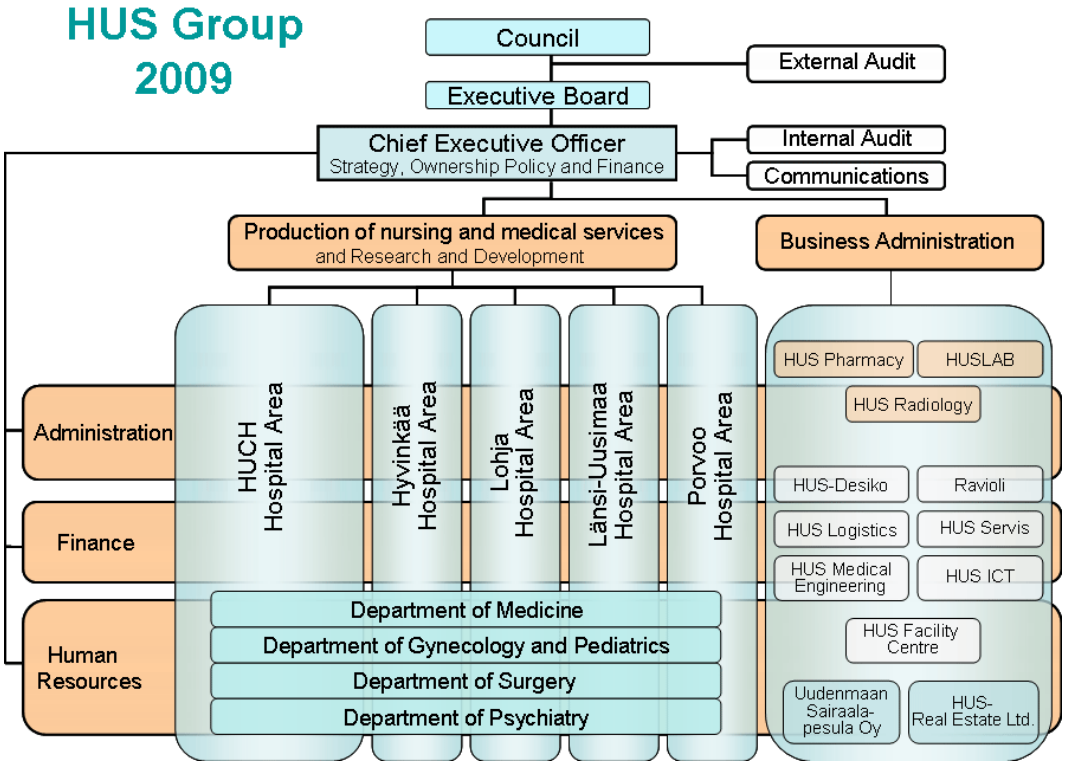
The primary objective of this research was to prepare a multifaceted report on the state of affairs concerning strategy execution at HUS as perceived by its key stakeholders in 2009. Specifically, the report is to analyze the strategy process in 2007 – 2009 from the stakeholder point of view to the extent that it develops and extends the understanding of future success factors for strategy execution at HUS. The objective was to verify which factors have had the main inhibitory impact on the overall acceptability of the strategy during the strategy process. It was also of interest to deepen the understanding of the stakeholder acceptability of the strategy after its revision in the end of year 2008.

The project was initiated out of the group members' own interest on the topical subject matter. The work was carried out independently rather than made to order. The research group found it important that all the stakeholders could trust the neutrality of the research group in conceiving the stakeholder perceptions of the strategy process.

1.2 HUS organization

For the organization of specialized medical care, Finland is divided into 20 hospital districts. Five of them are university hospital districts. The Hospital District of Helsinki and Uusimaa (HUS) is the largest of these. HUS as a joint authority serves patients by providing specialized medical care services for the residents of its 28 member municipalities.

HUS was established in 1999. It consists of 5 formerly independent hospital areas, namely the hospital areas of Helsinki University Central Hospital (HUCH), Hyvinkää, Lohja, Länsi-Uusimaa (Western Uusimaa), and Porvoo. The hospital area of HUCH is the largest of these as its budget accounts for about 80% of the whole HUS budget. In organizational matrix there are 4 profit units (departments) operating across the hospital areas, namely medicinal profit unit, operative (surgery) profit unit, profit unit of gynecology and pediatric care, and psychiatric profit unit. In addition, there are 9 business enterprises offering services such as laboratory, radiology, catering, logistic and maintenance services for the 4 profit units of HUS, municipalities and other health care organizations. The organizational structure of HUS is shown in more detail in a picture below:

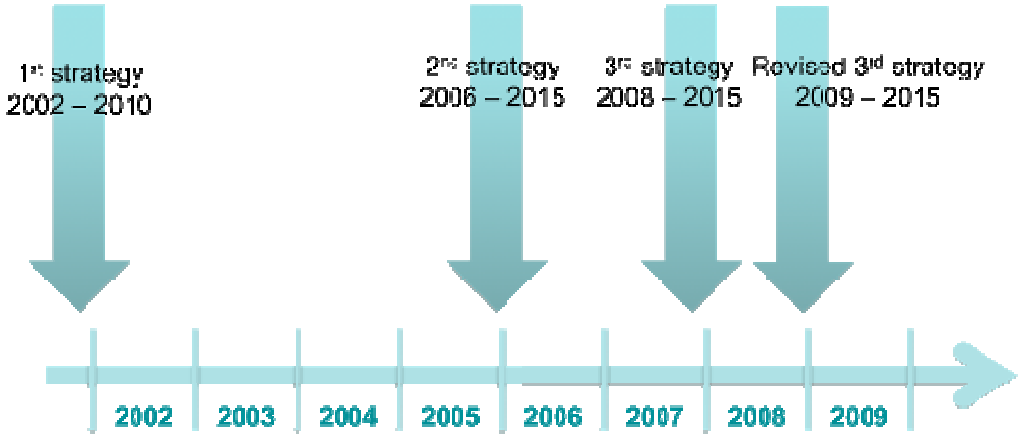


HUS offers medical care in 24 hospitals throughout the province of Uusimaa for the entire population base in the area. It represents 49 medical specialities including all of the major

specialities. Furthermore, as the largest university hospital in Finland, HUCH is nationally responsible for treating severe and rare illnesses and conditions calling for special expertise and technology. In the end of year 2008, there were a total of 20.956 people working for HUS, of which 80% in permanent positions.

1.3 Strategy of HUS

The mission of HUS is “to produce specialist healthcare services, and health benefits that drive the interests of – – customers, in productive cooperation with basic healthcare, the university and other partners” (HUS Strategy, 2009 – 2015). The Governance Rules of HUS stipulate that the joint authority is to be led according to a strategy with defined values and objectives. The strategy is set to form a key part of the joint authority’s steering system with reflections to annual financial and action plans. Furthermore, each HUS Council is expected to approve the strategic objectives at least once during its 4-year-term of operation (HUS Governance Rules, 1999 - 2009). The strategies of HUS are presented in a timeline below:



The very first strategy of HUS was approved in 2001 for the years of 2002 – 2010. It was the first effort to set common objectives for the joint authority, but its strategic objectives were found somewhat unrealistic a couple of years later (HUS Executive Board Meeting Memorandum 10.10.2005). An internal working group led by Chief Medical Officer formulated a new strategy for the years of 2006 – 2015. The second strategy emphasized the importance of patient and research focus and highlighted the value chain perspective in an objective of seamless cycle of care. HUS Council approved the second strategy with a remark that arrangements to follow should emphasize the significance of ownership in corporate governance (HUS Council Meeting Memorandum 15.12.2005).

In June 2006 HUS Council appointed a new CEO who was the first top executive to join the organization from outside the health care sector. The member municipalities had advocated the selection and mandated the newly appointed CEO to strengthen the

corporate governance of the joint authority. The newly appointed CEO presented his views on process of change to HUS Executive Board in January 2007. HUS Executive Board decided to initiate a third strategy process in April 2007 (HUS Executive Board Meeting 23.4.2007).

This report concentrates on analyzing the strategy process related to the third strategy for the period of 2008 – 2015. It was originally planned that the strategy would be formulated in 2007 and implemented as of year 2008. As explained in the subsequent chapters of this report, the strategy implementation faced strong opposition in 2008, which led to withdrawal of the original third strategy and formulation of a revised strategy. In this report the revision of the third strategy is handled as a complementing additional phase to the original third strategy process. The revision took place in a short period of October to December 2008 and was concluded by the approval of revised strategy for the period of 2009 - 2015 in the end of year 2008 (HUS Council Meeting 17.12.2008).

The third strategy process is explained and analyzed in more detail from a stakeholder perspective in the subsequent chapters of this report. The revised third strategy and all the three preceding strategies of HUS are listed with presentations of the strategic objectives in Appendix 1 of this report.

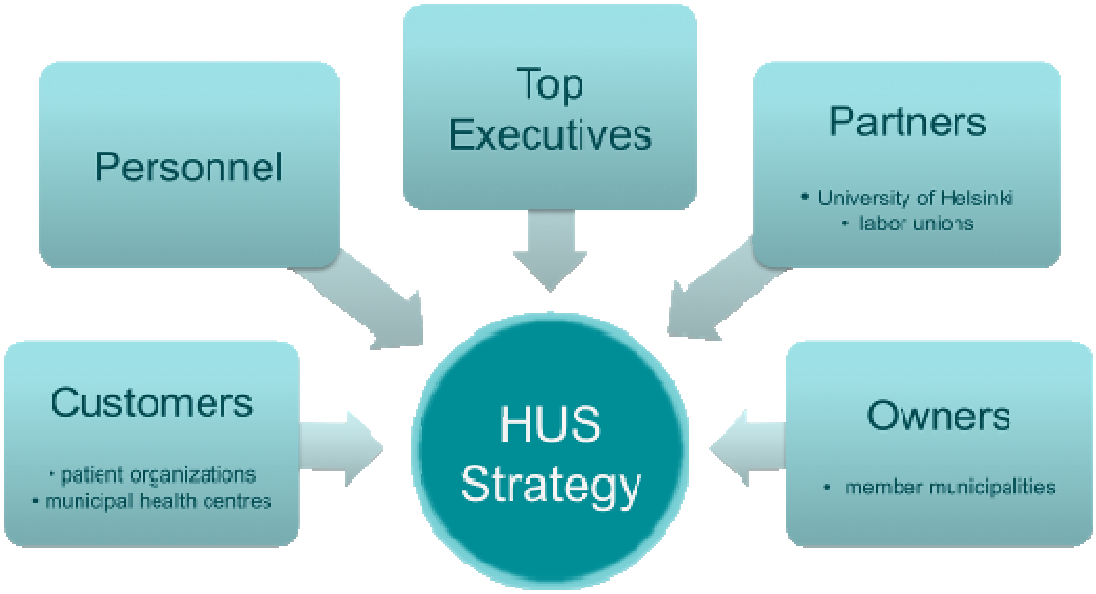
1.4 Stakeholders of HUS

As a public not-for-profit organization HUS is expected to pursue opportunities that provide maximum benefit to its key stakeholders. The extent to which HUS addresses the expectations of its key stakeholders is presumably reflected in the strategic objectives of the joint authority.

Both internal and external key stakeholders were identified for the purpose of this research. First of all, personnel and top executives (operative top management) were considered as internal stakeholder groups. Secondly, the key external stakeholders among the groups of customers, owners, and partners were identified. The identified key stakeholders can be summarized as follows:

1. Internal stakeholders: HUS personnel
2. Internal stakeholders: HUS top executives
3. External stakeholders: Customers (municipal health centres and patients represented by patient organizations)
4. External stakeholders: Owners (member municipalities represented by politicians in the elected decision making bodies of HUS)
5. External stakeholders: Partners (University of Helsinki and labor unions).

The overall key stakeholder scheme is set out below:



In this research labor unions are represented by two unions, namely the Union of Health and Social Care Professionals (Tehy) and the Finnish Medical Association (FMA). Tehy represents the interests of nursing staff, which is the biggest personnel group at HUS, whereas FMA represents the interests of physicians.

Of the elected decision making bodies representing owners HUS Executive Board manages the hospital district under the supervision of HUS Council. Therefore it was decided that chairmen of HUS Executive Board would represent owners in the interviews conducted for this research. Furthermore, it must be borne in mind that the interviewed municipal health centre officers represent not only customers but also member municipalities. Thus the representatives of municipal health centres act in multiple roles in their relations with HUS.

In fact, the multidimensionality of stakeholder roles is characteristic for the whole stakeholder scheme. For instance HUS Executive Board is not only representing the owners but also supporting the top executives in the strategic management of HUS organization. Furthermore, labor unions can be seen as partners but safeguarding the interests of employees within the organization. Also, patient organizations are representing patients as customers but can be considered as partners as well. Finally, University of Helsinki practices research and education of medicine within the HUS organization. This integral cooperation makes it a special partner for HUS. As discussed in the subsequent chapters of this report, even that University of Helsinki is an external stakeholder it has

significant influencing power especially through its link with an internal stakeholder group of personnel.

The list of interviewed stakeholder representatives is set out in Appendix 6 of this report. The list of key stakeholders defined for the purpose of this research is not exhaustive as such but includes the stakeholders identified to potentially have influence on the strategy process at HUS. The role of each stakeholder group in the strategy process at HUS is further analyzed and described in the subsequent chapters of this report.

1.5 Context of health care strategies

In this chapter the strategies of the Finnish university hospital districts are briefly discussed and compared to the strategy of Kaiser Permanente in the United States to describe the trends of strategic development in modern health care of today. The strategies are discussed in a framework of Michael E. Porter's model for value-based health care (Porter et al. 2006). The universally applicable principles of Porter's model have been utilized for analyzing the development needs of health care not only in the US but also in many other countries, including Finland (Teperi et al. 2009). The model therefore serves as a useful framework even for comparing the strategies of health care organizations in different countries.

In Finland there is a total of five hospital districts with university hospitals in their areas of responsibility. HUS is one of these and the other four are the hospital districts of Northern Ostrobothnia, Pirkanmaa, Southwest Finland and Northern Savo. Each of these university hospital districts provides specialized medical care services for its own population base, and also acts as a tertiary referral centre to a larger area. HUS is the largest of these hospital districts with a population base of 1.5 million inhabitants, the second largest being Pirkanmaa Hospital District with a population base of 500,000 people. The strategies of the other university hospital districts can be compared to the strategy of HUS keeping in mind the exceptional size of HUS compared to the others. In addition, the special national responsibility of HUS to provide treatments for some rare conditions (such as organ transplant surgeries) needs to be borne in mind.

Most of the elements in the strategic objectives of HUS can also be found in the strategies of the other university hospital districts. All the compared strategies include strategic objectives in the focus areas of patients, education and research, leadership, personnel, processes and structures, and owners and finance. The strategic objectives are mostly general and descriptive in nature, including goals such as efficient finances and good leadership. In many cases the general descriptiveness of the strategic objectives makes them appear self-evident in nature. The contents of the strategic objectives are compared

in a focus area level in Appendix 3 of this report. The comparison indicates clearly that the Finnish university hospital districts share fairly similar strategic objectives, even if phrased and presented a bit differently. The similarity can be partly due to the central governing of general health policy guidelines in the direction of the health care system at the state level. In Finland the national Ministry of Social Affairs and Health sets broad development goals, prepares legislation and other key reforms and oversees their implementation. Traditionally the main goal has been to ensure universal access to health services while attempting to restrain costs.

However, as pointed out by Teperi et al., it will no longer be enough for Finnish health care organizations to reach for the traditional goals (2009). The existing strategies are facing an increasing external pressure as the share of elderly population increases and municipal financing tightens. A refocus is needed in an attempt to bring the required value for individual patients and to ensure the financial sustainability of the system (Teperi et al. 2009). Therefore a forerunner hospital district should not only describe the self-evident operational principles but also strive for unprejudiced innovation in the strategic thinking. Specifically, Teperi et al. argue that competitive principles should apply even for public health care organizations for continuous improvement of health outcomes and the quality of full cycles of care (2009).

The strategic focus points suggested by Teperi et al. for Finnish health care are based on the principles of Porter's model presented in the book "Redefining Health Care: Creating Value-Based Competition on Results" (Porter et al. 2006). According to the model the central focus must be on increasing value for patients — the health outcomes achieved per euro spent. The value is determined in a medical condition level over the full cycle of care (Porter et al. 2006). Adoption of this kind of approach constitutes a strategic refocus from traditional cost effectiveness to value for patients. The principles of Porter are embodied in the strategic choices of Kaiser Permanente as explained later in this chapter.

Christensen et al. speak of disruptive innovation in transformation of high-cost expertise-intensive health care services into ones that are more affordable, accessible and simple without compromising the striving for better quality (2009). Christensen et al. argue that general hospital is not a viable business model due to several reasons. First of all, according to this view, the value proposition of a general hospital is excessive. A hospital typically promises to treat any condition and therefore entails high complexity overhead costs and a mixture of business models under the same roof. Christensen et al. also argue that the practice of subsidizing the unique, low-volume, specialized capabilities by keeping high-volume standardized procedures within general hospitals combined with lack of transparency in expenses and prices constitutes a challenge for the value creation in

general hospitals. Christensen et al. suggest rational integration around the “jobs of patients”, outcome orientation and creation of hospitals-within-hospitals with technological enablers for reaching focused business models for the realisation of systemic benefits in the holding company level (Christensen et al. 2009). These suggestions are in many respects in line with the principles of Porter et al., the main idea being that quality improvement and value creation for patients are not in contradiction with cost improvements. The extent to which Finnish health care organizations have included these recommended value bringing focus points in their strategies will be briefly discussed by analyzing the presence of these very principles in the strategic choices of Kaiser Permanente.

Kaiser Permanente is a not-for-profit integrated US based health care system providing both primary and specialized health care for its members. A brief description of the organization is included in Appendix 4 of this report. Kaiser Permanente has been recognized for its efficiency and high quality standards (Analysis of Hewitt Associates, 2009). The proclaimed success factors of Kaiser Permanente are visible in its strategic choices, which are described in a table in Appendix 5. In the table, each strategic choice is reflected to the potential challenges in Finnish health care. The identified potential challenges are derived from a holistic view of the Finnish health care system and constitute both national and organizational level development needs.

It can be concluded that the strategic choices of Kaiser Permanente apply the principles presented in the referred literature to a large extent whereas different approaches and circumstances can be detected in the current environment of Finnish health care strategies. Still only a couple of the identified challenges are fundamentally systemic in nature. The Finnish health care system, as it is today, doesn’t advocate deployment of competitive principles as such. Furthermore, in the US health care system a more integrated approach is possible compared to a fragmented Finnish health care sector. Still many of the strategic choices of Kaiser Permanente could be applied in Finnish health care organizations even in the current operating environment.

The presence of the recommended value bringing focus points in the current strategy formulations of Finnish university hospital districts is limited. However some exceptions do exist. For instance the Hospital District of Pirkanmaa promotes participation of patients, cooperation with primary health care, cycle of care orientation, and technological innovation for the support of health care delivery. These elements are included in the strategy definitions, but it is beyond the scope of this research to evaluate, whether these focus points are visible in the actual strategy execution as well.

Finally, the upcoming new health care legislation is likely to alter the current fragmented operating environment of Finnish health care considerably (Memorandum of the Working Group Preparing the Health Care Act, 2008). For instance the new legislation is expected to allow patients to seek for desirable service from a wider selection of providers, which contributes to the creation of a competitive environment and serves as an incentive to further innovation. Furthermore, the new legislation is expected to affect the distribution of health care provisioning responsibilities between primary health care and specialized medical care. Therefore, the new health care legislation is bound to stimulate strategic changes in Finnish hospital districts. In addition to the governmental inducement for hospital districts to redefine their strategies, a more proactive approach in strategic thinking is needed for the support of continued improvement.

Furthermore, as discussed in the subsequent chapters of this report, goal clarity is one of the prerequisites of strategy acceptance. Stakeholders are more likely to understand the necessity of strategic change, if the strategic objectives manifest expressions of innovative strategic choices rather than descriptions of current state of affairs.

1.6 Project scope and limitations

As strategic management is not an internal process only but involves interaction with external stakeholders of the organization, data has been collected not only from the HUS organization but external stakeholders as well. To limit the project scope and the data collection, key stakeholders were identified. Thus this project is not considering the views of all the stakeholders of HUS. It addresses only the viewpoints of the key stakeholders as discussed in the chapter 1.4 of this report.

The perceptions of stakeholders are considered primarily in respect to the strategy process. The contents of the strategy are considered only to the extent that they are considered to have a significant effect on the stakeholder acceptance of strategy. Furthermore, according to the Governance Rules of HUS, the strategy of HUS consists of vision, mission, values, strategic objectives, and related measurable goals (HUS Governance Rules, 1999 - 2009). In this project, the focus is on HUS level strategic objectives that constitute a core element of the whole strategy to be defined and executed during a strategy process. For instance this report does not evaluate the process of redefining the organizational values that coincided with the process of redefining the strategic objectives.

The data collection methods are discussed in chapter 3 of this report. The methodology imposes the project to certain limitations in terms of the generalization of the inferences. For instance it must be borne in mind that despite the interviewed persons awareness of

their responsibility to express primarily the ideas of their own respective stakeholder groups, the individual opinions are bound to affect the statements as well. However the research group remains confident that the chosen interviewees were well informed of the stakeholder group's shared views on the subject matter. Any indications of individual thinking contradicting the shared views of the respective stakeholder group were taken into account in the interview data analysis and consequent inferences. Furthermore, the restricted sample size of the telephone survey has been taken into account by applying a careful approach in making any extrapolations on the grounds of the survey data.

1.7 Structure of report

This introductory part of the report will be followed by a literature review and a presentation of the theoretical framework chosen for this research. After that the chosen methodology is explained in detail. The data analyses are reflected in the following chapter by explaining the findings from stakeholder perspective. The chapter of findings includes both description of the strategy process as perceived by stakeholders and a description of the strategy acceptance level at the time of collecting the data for this research in the summer of 2009. Finally, an analysis of reasons for failure of strategy in 2008 is followed by a description of identified future key success factors of strategy execution as a resultant. The report is concluded with discussion, research evaluation, conclusions and recommendations.

2 Theoretical framework and literature

2.1 Stakeholder theory

Freeman defines a stakeholder as "any group or individual who is affected by or can affect the achievement of an organization's objectives" (Freeman et al. 2001). According to Johnson et al. "stakeholders are those individuals or groups who depend on an organization to fulfil their own goals and on whom, in turn, the organization depends" (2008). Freeman originally built stakeholder management as a new strategic management framework to support corporate governance in an environment of increased accountability to wider stakeholder interests (Freeman et al. 2001).

Stakeholders may have a number of sources of power that help them influence the organization's strategy. Therefore it is important to understand different stakeholder expectations and their relative influence on strategic purpose. Furthermore, it is important for top executives to understand not only expected reactions of different stakeholders in general but the potential reactions of the actual stakeholders of the organization in the specific circumstances they find themselves in. Power and interests of different

stakeholder groups can be evaluated by the means of a stakeholder analysis to be carried out as part of the environmental analysis phase of the strategy process (Freeman et al. 2001).

A systems theory application in stakeholder theory suggests that problems can only be solved with the support of all the stakeholders in a network consisting of an organization's stakeholders. The systems theory emphasizes the development of collective strategies that optimize the network (Freeman et al. 2001). As pointed out by Johnson et al., since the expectations of stakeholder groups tend to differ, it is common for conflict to exist regarding the importance or desirability of many aspects of strategy (2008). Top executives need to find a balance in the relationships among stakeholders within the network. Compromises often need to be made. Therefore taking not only stakeholder expectations but also influence into account is an important aspect of strategic choice. Thus stakeholder management requires balancing and integration of multiple stakeholder relationships, objectives and values. Furthermore, stakeholder management approach suggests that stakeholder relationships can be influenced in strategic partnerships, not just taken as given (Freeman et al. 2001).

Finally, stakeholder approach to corporate governance provokes debates on top executives' primary duties. In principle, top executives have a contractual duty to manage an organization in the interests of owners but at the same time hold a moral duty to take other stakeholders into account (Freeman et al. 2001). Furthermore, it can be argued that success of the organization and its owners will depend on top executives' ability to take the interests of other stakeholders into account. An organization succeeds in its strategic endeavours only if perspectives of all key stakeholders are integrated in the strategy.

2.2 Stakeholder acceptance of strategy

According to Johnson et al. the success of a strategy depends on three factors: suitability, feasibility and acceptability (2008). First of all, a strategy is suitable, if it addresses the key strategic issues and makes economic sense in the environment considering the organization's strategic position and capabilities. Secondly, a strategy is feasible, if the resources required to implement the strategy are available, can be developed or obtained. Thirdly, a strategy is acceptable, if it meets the expectations of the identified stakeholders. The stakeholder expectations concern the expected return (financial and non-financial benefits) from the strategy and the expected level of risk (probability and consequences of a failure). The evaluation of stakeholder acceptability involves assessment of the likely reaction of stakeholders to the expected performance of strategy according to each of the success factors. In this context, the expected performance of strategy should be evaluated

by analyzing, how each stakeholder group perceives not only the feasibility and suitability of the strategy but also the expected benefits and level of risk associated with the strategy.

A strategy is acceptable only if it meets the expectations of all the powerful key stakeholders likely to react to any unmet expectations. As discussed earlier in this report, stakeholder analysis methods exist for assessing the power and interests of different stakeholder groups in given circumstances. Such an analysis supports preparation of a stakeholder involvement plan to be made prior to the actual initiation of the strategy process. Freeman suggests that after the identification and prioritization of key stakeholders, the different needs and expectations should be assessed, ideas collected and finally integrated into the strategic management process (Freeman et al. 2001). These steps are essential for ensuring strategy acceptance among all key stakeholders.

2.3 Challenges to implement change from stakeholder perspective

In their article Peltokorpi et al. discuss the factors affecting the level of challenge to change implementation (2008). The authors define the factors based on stakeholder theory literature and test the derived model's practical validity for screening change initiatives in a presented case example from health care sector. According to the defined model, change initiatives can be evaluated using six factors of which four are stakeholder specific factors: capability to change, effect on stakeholders' actions and position, influencing possibilities, and goal clarity. These four stakeholder specific factors and two general factors, namely change complexity and management capability, can be used for assessing challenges to implement change.

Execution of strategy at HUS imposes the organization to a prospective change. As explained later in this report, many stakeholders claimed that all the historic strategies of HUS remained unimplemented. Therefore in case of HUS, introduction of a new strategy with strong execution intentions, no matter what the contents of the new strategy, constitutes a change initiative as such. Thus the 6-factor-model suggested by Peltokorpi et al. can be used for evaluating the challenges related to the strategy process at HUS. The identified challenges are the factors that have had a negative impact on the stakeholder acceptability of the strategy. Addressing the identified issues lead the research group to suggest the key success factors for future strategy execution at HUS.

In the context of strategy execution, the six factors prevent stakeholder acceptance and success of strategic change as explained briefly herein. First of all, strategic change is difficult to execute, if a change in the prevailing organizational culture is required. Secondly, strategic change is more likely to be resisted by a stakeholder group if it assumes that the change will affect its position and there is no match between the goals of

the change and the stakeholder goals. Thirdly, strategic change is more likely to be resisted by a stakeholder group if it hasn't had the possibility to participate in the strategy process. Fourthly, a stakeholder group is more likely to lack motivation to participate in the strategic change, if the goals are unclear. Goals are unclear, if there is no clear indication of additional benefit for the stakeholder group. Additional benefit should be pointed out by explaining, why change is needed. Fifthly, a stakeholder group is more likely to lack motivation to participate in the strategic change, if it assumes the implementation to be complicated for instance due to competing goals of different stakeholder groups. Finally, stakeholder independence and propensity to resist change restricts the top executives' power and authority to implement changes. All these factors affect the stakeholders' benefit and risk expectations and therefore have an impact on stakeholder acceptability of strategy.

2.4 Strategic management in health care

As Parvinen et al. conclude health care is a multifaceted cluster with a whole group of loud and influential stakeholders with diversified goals (2005). Balancing the different stakeholder interests is a true challenge for the governance of a health care organization. It could be concluded that the main task of the governance model is to build and maintain conditions, where the actual health care service production can perform well according to the strategy of the organization. These conditions require that different stakeholder expectations are considered and managed to ensure a balanced strategy and stakeholder commitment to any strategic changes. At the same time a risk of leading through compromises need to be acknowledged. An efficient leader executes by merging views and reaching commitment to strategy and goals whereas excessive participation and democracy may lead to inefficient compromising. Thus active stakeholder management is called for when leading any strategic changes or processes in an organization. Moreover there are some factors especially prominent in health care organizations to be considered in strategic management in order to manage any challenges to change. These factors include strong professions, political governance, skills of middle management and the self-evident nature of public health care organization's mission.

Firstly, a strong internal stakeholder group of personnel commonly advocate substance orientation in the organization of health care production. Therefore there is a specific challenge of combining governance and substance in the strategic management of health care. In a health care organization the profession of physicians typically maintain an autonomic area of operation based on their special expertise in matters of life and death. There exists borders between professions and conflicts between individual actors and top executives are not unusual. It is quite common for the strong profession of physicians to expect medical substance from general management for leading the governance and

strategic thinking in the organization (Parvinen et al. 2005). The requirement to obtain both medical substance and governance knowledge in the leadership function is sometimes addressed for instance by distributing the leadership responsibilities discretionarily. Furthermore, requirement of professionalism in leadership has urged many health care organizations to adopt new leadership doctrines from other industries and branches of science (Parvinen et al. 2005).

Implementation of any strategic changes requires that special attention is paid to stakeholder management of the internal stakeholder group of employees with strong professions. For a health care organization Parvinen et al. suggest a resource based strategy that emphasizes the importance of the organization's unique resources and knowhow as sources for operational excellence (2005). Such a strategic approach promotes participation of the unique resources in strategic planning for taking the best out of the opportunities arising in the environment of operation (Parvinen et al. 2005). A creative organization has the capability to brainstorm, innovate and create something new but still the challenge to manage a creative organization needs to be acknowledged.

Secondly, public health care imposes the organizations to political governance. A public health care organization needs to combine strategic management and execution of political decisions. The political decision making model remains a constant matter of debate among different stakeholders.

Thirdly, middle manager positions in health care typically require education in medicine, but the level of leadership training is limited in the training program of medical specialists. According to a survey by the Ministry of Social Affairs and Health in Finland, 81% of the physicians with a recently completed specialist degree claim that their education did not provide them with a sufficient level of education in leadership skills (Vänskä et al. 2005). Nevertheless it is a task of middle management to lower the intra-organizational boarders and promote cooperation, which are essential elements in strategy execution. A fundamental problem in health care is that middle managers are typically in charge of operational functions but do not have the required overall responsibility of the operations and the related results. It is extremely difficult to implement changes in a level of the whole organization, if middle managers are in a position to sub-optimize. Strategy execution requires that middle managers not only have a sufficient level of authority but a desire to reach the results according to the goals and resources defined by the top executives. Middle managers need to be able to accept the stance of the whole organization. Furthermore, the requirements include capability to communicate any signals to top executives, sell ideas and get a sufficient level of authority from top executives.

Fourthly, in public health care the mission to help people is naturally strong. The intuitively conceivable mission is so inherent that envisioning, value discussion and goal setting require further boost (Parvinen et al. 2005). It is not intrinsically obvious for all involved that a strategy of a health care organization could be something else than a manifestation of the axiomatic duties and operations of the organization. A strategy should express strategic decisions rather than self-evident facts such as profitability and efficiency that are not even choices as such (Parvinen et al. 2005). True strategic decisions on long-term goals require not only thorough understanding of environment and resources but also stance on efficient execution. Thus a strategy process of a health care organization should pay special attention to the means of formulating strategic objectives that are of strategic significance for the organization. The trends of health care strategies are further discussed in chapter 1.5 of this report.

3 Methodology

This chapter is to describe the actual research process and the methodology applied at each stage. Specifically the chosen methods of semi-structured interviews and telephone survey are explained. The grounds for selecting these specific data collection methods are briefly discussed herein.

The semi-structured interviews were selected as a primary means for data collection to take advantage of the exploration possibilities brought by this method. The purpose of this project was to describe and understand the complexity of stakeholder perceptions of strategy process. In qualitative methods, the opinions, attitudes and points of views of interviewees are heard in a wider spectrum compared to statistical surveys with strictly pre-defined questions. Therefore in this research semi-structured interviews performed better than statistical surveys especially in exploring the perceptions of other stakeholders than personnel. Also, the number of required interviews was limited, which allowed the research group to select the semi-structured interview method instead of a more structured approach. Still the original script of the semi-structured interviewers guaranteed the uniformity of covered topics across the whole sample.

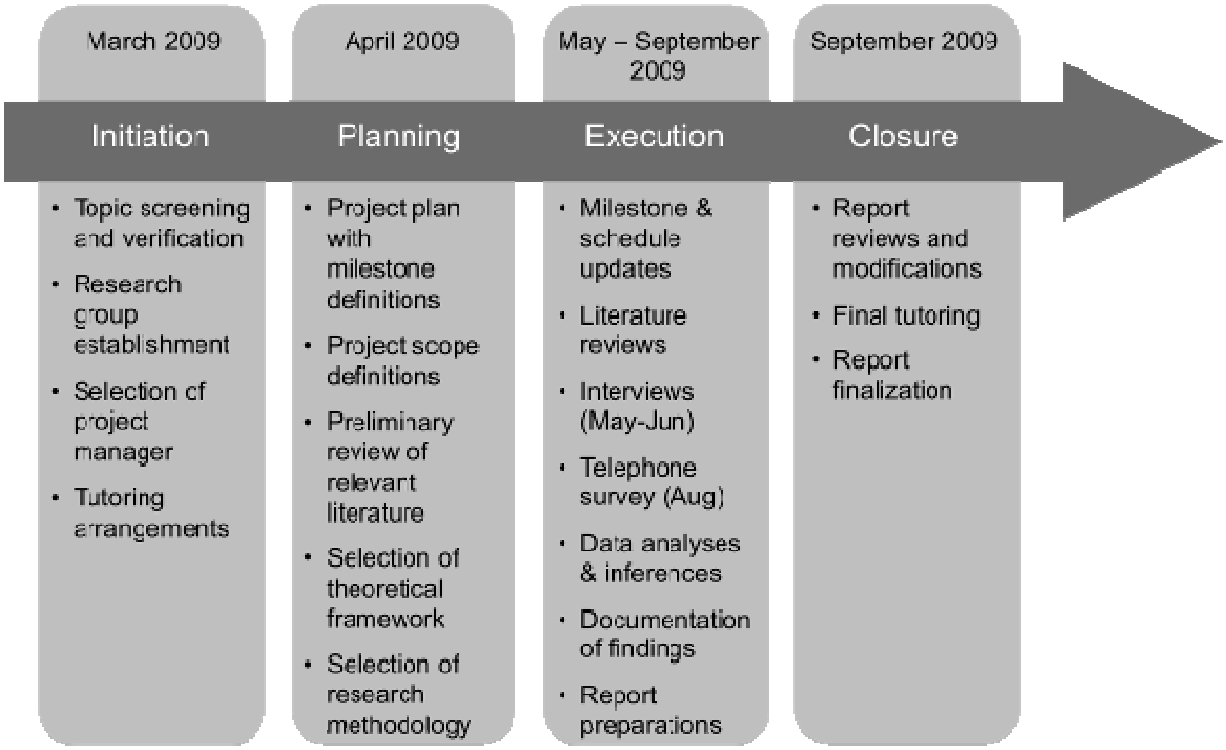
Already in the early stages of the project it was clear that a different method for data collection should be used in the stakeholder group of personnel. It was agreed that the data collection should be made in as delicate manner as possible considering the controversy surrounding the recent strategy process within the organization. A method of telephone survey was chosen and it was targeted to a limited number of respondents. The preliminary analysis of interview data from other stakeholder groups had revealed quite clearly that many perceived the middle managers, employees in superior positions, to play

a critical role in creation of strategy acceptance within personnel. Therefore the sample for the telephone survey was drawn from the personnel group of superiors. The telephone survey allowed a larger sample compared to partly-structured interviews and proved to be a delicate enough approach for exploring the views among the stakeholder group of personnel.

The more detailed explanations for the selected methods are provided in the subsequent chapters. Also, the performance of the selected methods in this research is evaluated. The validity of the results is further discussed in chapter 6.2 of this report.

3.1 Overall research process

This business project has been an independent research effort without any liaison to other research project in the area of this subject matter. The project was initiated and performed independently of the HUS organization and its stakeholders. The selected internal and external stakeholders took part of the project as interviewees. The research group was tutored by Mr. Vesa Kämäräinen from Nordic Healthcare Group Ltd. The research project phases and main tasks are set out below:



A more detailed milestone description is set out in Appendix 12 of this report.

The subject matter of the project raised positive interest within the interviewed stakeholders. The research group will provide HUS with copies of this report. In addition, other stakeholders will be provided with the report or a summary of the project findings.

3.2 Semi-structured interviews

The research was mostly based on qualitative data from semi-structured interviews. All the stakeholders except HUS personnel were interviewed based on this specific method (see chapter 3.3 for data collection from personnel). The qualitative data was collected both to support a set of preliminary hypotheses and to reveal any new information on the subject matter. Thus the data was used for explorative purposes as well without hypothesis testing. The inferences were reflected to chosen theoretical framework to check whether the data served as an evidence for the appropriateness of the theories in this context.

The identification of persons to be interviewed was based on discretionary selection. This selection method was partly due to the high variance in the stakeholder group sizes. Also, the chosen people had observed closely the strategy process or hold a key position within the stakeholder group. Still special attention needs to be paid if findings based on individual interviews would be generalized to stakeholder group levels.

The research group succeeded in arranging all the planned interview appointments. The interviews were conducted within a short period of time (in 1 month) allowing the interviews to reflect their perceptions in a same situation in relation to the stage of strategy execution. Only one appointment was organized on a later date. In addition, one candidate had to refuse due to shortage of free time for appointments within the required schedule. The refusal did not constitute a problem to the overall data collection as there were two other candidates from the same stakeholder group that agreed to participate as interviewees in the project. The interviewees and appointment dates are set out in Appendix 6 of this report.

The interview questions were based on a set of hypotheses that was derived from the available literature and theoretical framework. All the questions were same for all the interviewees except for HUS top executives and chairmen of HUS Executive Board. For them there were some additional questions and some alterations to the otherwise similar questions presented to other stakeholder representatives. The pre-defined questions are set out in Appendix 7 of this report.

The interviewees were not familiar with the interview questions in advance. The idea was to generate spontaneous answers with free discussion within the context of the semi-structured interview. Considering the complexity of stakeholder perceptions of strategy

process and the affecting factors it was not justifiable to limit the discussion during the interviews to the pre-defined questions only. The factors affecting the perceptions of the strategy process depend greatly on the contextual setting, which was to be explored by a means of free discussion during the semi-structured interviews. In practice, all the pre-defined questions of the semi-structured interviews were presented, but the interviewees were quite freely allowed to express their thoughts around the subject matter (free association). The pre-defined questions were presented in three sections that correspond the stages of a strategy process. This structure was to make the interview process clearer for the interviewee.

The first part consisted of questions related to the situation analysis and strategy preparation phase, the second part focused on the strategy formulation and planning phase and the third part handled the questions related to the strategy implementation phase. This structure led in some instances to situations, where the interviewee discussed broadly the subject matter even before urged with more specific questions. In those instances the interviewees were allowed to refer to earlier discussion and the interview flowed onwards fluently. On the other hand the more specific questions gave the interviewees a chance to fill in some more details, which gave the interviewers deeper understanding and data on the subject matter. Overall, the interview structure of three parts was perceived to help both the interviewees and interviewers to comprehend the interview process and perform better in the conduction of the interview in a structured way without pressing down any free association. Free association was encouraged not only in reflection of the past strategy process but also in presentation of ideas for future success factors in strategy execution.

The overall atmosphere in the interviews was created by providing each interviewee with a clarifying brief review of the project and interview purpose, which was given orally in the beginning of each interview prior to starting with the actual questions. The oral briefing was supported by two documents that were handed out to the interviewee to use during the interview. The other document was a picture presenting the timeline with HUS strategies on it (see chapter 1.3 for the timeline picture). The other document showed a map of key stakeholders (see chapter 1.4 for the key stakeholder map). In addition to the briefing by the interviewer, the interviewees were given a chance to briefly describe their relationship to HUS for record and warm-up purposes.

All the research group members took part on the interview data collection. There were 2 interviewers in each interview except in 1 where there was only 1 interviewer presenting the questions. The interviewers perceived the atmosphere in all the interviews constructive and open. The interviewees expressed a generally positive attitude towards the interviews

and the interviewers. The duration of the interviews varied from an interview to another as the interviewees shared different ideas for each broad question. The average duration of an interview was about 60 minutes. The number of semi-structured interviews amounted to 15.

The interviews were recorded and written down based on the recordings right after the meetings. The amount of interview data was extensive. The transcriptions were written down with all the words spelled out by the interviewees. Only filling sounds between words and sentences were excluded from the transcriptions. All the members of the research group read the transcriptions. The data analysis was based on both deduction (theory orientation) and induction (data orientation). Thus abduction, a combination of deduction and induction, has been the analysis method of the semi-structured interview data. A set of hypotheses based on the theoretical framework was used but also exploration of data was made to describe the phenomenon related to the subject matter. The purpose of this study was to describe and understand the phenomenon in more detail rather than to reveal an exhaustive explanatory model for the phenomenon.

The interview data was analyzed by grouping the data to themes based on the chosen theoretical framework. The data was compared to the theoretical framework and related set of hypotheses. Support for the interview data analysis was searched from a selection of documents describing the actual events during the strategy process at HUS. First of all, HUS Governance Rules (1999 – 2009) as well as the most recent HUS Personnel Report (2008), HUS Annual Report (2008) and HUS Audit Board Report (2008) were analyzed. Furthermore, a memorandum prepared by an internal investigator for HUS Executive Board was reviewed (Tuominen, 2008). The memorandum concerns reformation of the management system in the production of health care services, which coincided with the strategy process. Despite the availability of these documents, the writers decided to rely mostly on the interview data and did not make any inferences based on information from other sources without supportive information pulled out from the interview data.

In the interview data analysis phase the research group concluded that the pre-designed questions proved to be valid and effective in the exploration of the subject matter. The questions activated answers that generated data to verify the appropriateness of the chosen theoretical framework and the related hypotheses. Moreover, the interview data turned out to be quite comprehensive and the interviewees seemed to understand the questions in the way meant by the interviewers. In some cases the interviewees asked the interviewer to repeat or re-formulate the question, which ensured that the received answers correspond the meant purpose.

3.3 Telephone survey

The perceptions and attitudes of HUS personnel were investigated by collecting quantitative data by a means of a telephone survey. The survey consisted of 33 pre-defined statements and 6 questions with pre-defined answer choices. Thus the chosen method was a structured interview, which was targeted especially to employees in a superior position within the organization. This specific method was selected due to the reasons explained herein.

First of all, there are over 20.000 people working for HUS. Exploring the views on the subject matter in an extensive population like this requires that as many respondents as possible are heard for the research. A natural choice of method would have been a statistical survey, which could have been arranged as a web survey. However the research group decided not to use such a method of data collection in this case. The reason for this was based on an observation that strategy still is a potentially controversial subject within the HUS organization. Many stakeholders reported in the semi-structured interviews, that the internal turmoil around the strategy process in 2008 has now cooled off but is still in fresh memories of personnel. It was concluded that an impersonal web based survey could agitate unwanted reactions and unfounded speculations on the purposes of the survey. Furthermore, such a web survey was feared to provoke extreme responses but not to attract the responses of employees who do not feel so strongly of the subject matter but are tired of the strategy related discussion within the organization. Telephone based structured interview was assumed to attract high response rates throughout the target group and contribute to reduction of self-selection bias.

Secondly, many stakeholder representatives reported in the semi-structured interviews that it was the middle management that played a crucial role in the overall acceptance of HUS strategy. For instance it was reported that the strategy implementation is supposed to follow the line-management structure within the organization. Without commitment and acceptance in the middle management the personnel is unlikely to accept the strategy as a whole. Furthermore, some stakeholders concluded that there are lots of employees who are not familiar with the subject matter in a deeper level. The role of middle management as a strategy executor in the everyday hospital functions was emphasized. Due to this reasoning it was decided that the perceptions of HUS personnel should be explored by directing the survey to middle managers only. The exclusion of other personnel was a decisive factor in selecting telephone survey as a data collection method.

The respondents to the telephone survey were determined by respecting a principle of random selection of people from the survey population. First, the survey population from

which the sample was drawn was defined. The survey population in this case consisted of employees in a superior position at HUS. The survey population excluded the superiors in HUS group administration and affiliating companies. Furthermore, from other hospital areas than Helsinki University Central Hospital (HUCH) only superiors of nursing staff and physicians were included in the survey population whereas from HUCH superiors of other personnel were included as well. The reason for the latter exclusion was that the presence of other occupations than physicians and nursing staff is very limited in other hospital areas than HUCH.

The identification of the employees in superior roles at HUS was based on job titles with certain basic rules for the reasoning. For instance it was concluded that all the employees with job titles starting with a term “leading” should be considered as people in superior positions within the organization. For a more detailed analysis on superior job titles see Appendix 8 of this report. After identification of superior job titles a list of survey population was created by pulling out the relevant records from lists of contact details at HUS. The main source was a database of e-mail addresses that was complemented with information from databases of telephone numbers. This database exploration resulted in a population of about 1700 people in superior positions at HUS.

It was concluded that a sample of 105 people would be drawn from the defined population. Thus the sample was designed to cover 6% of the survey population. The telephone surveys were to be conducted by the research group members themselves, which meant that each research group member was to conduct an average of 21 telephone surveys and document the results accordingly. The 105 people were selected randomly by respecting a pre-defined sample plan.

The main principle of the sample plan was that the respondents were to be drawn from specific sub-populations. These sub-populations were formed based on hospital areas (HUCH, Hyvinkää, Lohja, Länsi-Uusimaa and Porvoo) and staff groups (physicians, nursing staff and other staff) which led to a total number of 11 sub-populations. In addition all the HUS business enterprises (9 in total) were grouped into 2 sub-populations according to the sizes of personnel. The other sub-population of HUS business enterprises consisted of smaller enterprises with less than 500 employees each (5 enterprises with a total of about 1000 employees) and the other sub-population consisted of larger enterprises with more than 500 employees each (4 enterprises with a total of about 5300 employees). As a result 2 sub-populations of HUS business enterprises and 11 sub-populations of hospital areas and staff groups were identified (13 sub-populations in total). The number of respondents to be drawn from each sub-population was calculated based on the number of people in superior positions in each of the sub-populations. For instance

25% of the people in the survey population were identified to work in a superior position for HUS business enterprises. Thus 25% of the 105 respondents (26 respondents) were drawn randomly from the sub-populations of smaller and larger HUS business enterprises. The rest of the respondents (79 respondents) were drawn randomly from the other sub-populations according to the proportions of people in superior positions in the survey population. In case of each sub-population, a minimum requirement of 2 respondents per sub-population was respected.

After the execution of the random selections the contact details and job titles of all the selected people were checked. The main purpose of this was to verify the superior position and the relevant sub-population of each selected respondent. In case of any misconceived details affecting the sample generation, a renewal of the respondent selection was performed until a full list of 105 respondents was verified with valid information. Furthermore, some respondent selections were renewed in case the originally selected respondent was not reachable (for instance due to the vacation season).

The telephone surveys were conducted in August 2009. First, an informative email was sent to the respondents in order to notify them of the upcoming survey telephone call. The respondents were called soon after that. Most of the selected people were willing to contribute by participating in the survey. Only a few respondents had to refuse mainly due to lack of time. Still a total number of 105 respondents was reached by arranging renewals of the sample drawing as described earlier herein. 70% of the interviewed employees were women and 30% men. The ages of the respondents varied between 32 years and 65 years with an average of 52 years. The average duration of the current term of employment among the respondents was 19 years. A summary data of the interviewed employees' background information is set out in Appendix 9.

The quantitative data was collected both to support a set of preliminary hypotheses and to reveal any new information on the subject matter. However the data was mainly used for getting further evidence on the hypothesis testing related to the semi-structured interviews. The exploratory analysis of the data was very restricted as the survey was based on pre-defined collection of statements with multiple pre-defined answers to choose from. The respondents were asked to state whether he/she was fully agreeing (5), partly agreeing (4), neither agreeing nor disagreeing (3), partly disagreeing (2) or fully disagreeing (1) with the statement. In addition, the respondents were allowed to report of their ignorance in relation to each statement. The research group designed the statements based on the chosen theoretical framework and the preliminary inferences from the semi-structured interviews. Extra attention was paid to the clarity of the statements and the overall

lightness of the survey. See Appendix 10 for the statements presented to the respondents during the telephone survey.

In case of this specific telephone survey special attention needs to be paid to the generalization of the findings based on the sample data. It is by far too straightforward to assume that the statistics calculated from the sample data would represent the state of affairs in HUS personnel as a whole. Respectively one has to be careful in the generalizations to middle management as well. However the results combined with the findings from the semi-structured interviews provide useful indication of the current views concerning strategy within HUS personnel especially among middle managers.

It is evident that there are considerable variations in the opinions, perceptions and attitudes of HUS personnel. One of the purposes of the telephone survey was to make some of these variations visible as the earlier public discussions have suggested that HUS personnel as a whole would share a certain standpoint to the subject matter. However, it is to be noted again that such revelation of differences in perceptions between sub-populations or other sub-groups of HUS personnel are to be handled as purely indicative due to the restricted size of the sample in the survey. Bearing in mind these limitations of generalizations, one has to remember the preliminary purpose of the telephone survey. That was to collect supporting data for verifying the inferences that were made based on the semi-structured interviews of other stakeholder groups. HUS personnel plays an integral part in the overall strategy process and all the stakeholders were considering the personnel's points of view throughout the interviews according to their specific knowledge of that perspective. Some of the interviewees heard in the semi-structured interviews were actually representing HUS personnel as they spoke despite their defined primary role as a representative of another stakeholder group in the interview.

The average duration of the telephone surveys (structured interviews) was about 10 - 12 minutes. The interviewees were not familiar with the pre-defined statements. In other words, the statements were not sent to the interviewees in advance. The idea was to get the spontaneous answers within the context of the structured interview. All the writers of this report took part on the telephone survey data collection. The interviewers perceived the atmosphere in the telephone conversations constructive. The respondents expressed a generally positive attitude towards the telephone survey.

The gathered telephone survey data was imported to a centralized file in SPSS for data mining and statistical analysis. The file consisted of 105 observations corresponding to the number of respondents and 50 variables. 17 of the variables were mainly string variables for dividing the respondents into different categories based on their background data. Of

these categorical variables staff group and hospital area (or category of business enterprises) turned out to be most useful for data exploration purposes. The rest of the variables, 33 in total, were numeric variables in a Likert scale, which is a scale for ordinal, ordered categorical, data. For data exploration purposes the 5 alternative responses ranging from strongly disagree to strongly agree were in some cases combined to 3 categories, namely the response categories of agree, neither agree nor disagree and disagree. The central response alternative offered a possibility to take a neutral standing on the statement whereas a separate alternative response of “can’t say” was reserved for uncertain respondents. The “can’t say” responses were treated as missing values in the data analysis.

The data analysis was based mainly on evaluation of correlations, averages, distributions, and number of missing values. The data was explored by analysing these metrics in the whole sample and also in subpopulations of different types. The subpopulations were formed based on the categorical variables, such as staff group and hospital area. In the comparisons between different staff groups the main focus was in the largest staff groups of nursing staff and physicians due to the limited amount of respondents from the staff group of other personnel. Furthermore, the semi-structured interviews had indicated that nursing staff and physicians were the most active staff groups in the strategy process.

In the data analysis phase the research group concluded that the pre-defined collection of statements proved to be fairly valid in the exploration of the subject matter. The survey data was especially useful in getting further evidence on the hypothesis testing related to the semi-structured interviews. Moreover, in most of the cases the interviewees seemed to understand the statements in the way meant by the interviewers. In some cases the interviewees asked the interviewer to repeat the statement or the answer alternatives, but any re-formulation was avoided by the interviewees. Therefore the interpretation of statements was left to respondents’ sole discretion for ensuring a consistent data collection method.

The results of the survey data analysis are referred to throughout this report, but a more detailed presentation of the selected findings is set out in Appendix 11 of this report.

4 Findings

In this chapter it is explained, how different stakeholders perceive the strategy process of 2007 - 2008. Furthermore, the current level of strategy acceptance (at the time of data collection in the summer of 2009) is briefly described. Finally, the different stakeholder points of view are further described.

4.1 Stakeholder perceptions of strategy process

In the subsections of this chapter the strategy process is described as explained by the interviewed stakeholders.

4.1.1 Strategy process in 2007 - 2008

The third strategy of HUS has its origins in an externally imposed need to renew the strategy. Specifically, the member municipalities had expressed their wish to ensure stronger corporate governance and balance in HUS finances. The newly appointed CEO advocated reinforcement of strategic management in the organization and initiated the strategy process according to the decision of HUS Executive Board in April 2007. The ultimate goal was to introduce the organization with a new strategy that would be the first one to be actually implemented in the organization. The previous strategy had been in place but unimplemented since 2006.

Top executives identified the key stakeholder groups and their powers intuitively prior to the initiation of the strategy process. Top executives did not use any specific stakeholder analysis method for assessing, whether stakeholders should be involved in the strategy process. According to top executives, all the key stakeholders were requested to participate except for patient organizations that were considered to have a role in operative matters of patient interests rather than in strategic planning at HUS. Stakeholder participation was arranged mainly by inviting certain representatives from each stakeholder group to participate. The selection of the representatives from each stakeholder group is discussed in the subsections of the following chapter.

The third strategy of HUS was to be formulated in a working group led by the CEO and joined by top executives and selected representatives from personnel. HUS Executive Board and the working group started the strategy process officially in a 2-day seminar with representatives from selected member municipalities, trustees from labor unions and University of Helsinki. Strategy formulation was continued in further meetings of the working group. HUS Executive Board closely monitored the strategy process and received

reports of the progress throughout the year 2007. HUS Council approved and confirmed the strategy in December 2007.

The third strategy introduced strategic objectives in a couple of new focus areas. First of all there was a new financial objective of predictability and balance in finances. Secondly, owners and governance were included as a new focus area in the list of strategic objectives. The introduction of these strategic focus areas reflected the mandate given by owner municipalities through the elected decision making bodies of HUS Council and HUS Executive Board to the new CEO for strategy redefinition. The new strategy also differed from the previous one in other respects. It lacked a process development approach with a full cycle of care perspective as a means to improve care delivery. The strategy spoke of customers instead of patients. Expertise and humanity were not specifically mentioned in the objective of leadership anymore. Furthermore, instead of listing specific HR activities the strategy set a general goal of being an attractive workplace. As a result, the spirit of the strategy was perceived to be different compared to the previous strategy, even though most focus areas were fairly similar to the focus areas in the preceding strategy. The exact wordings of strategic objectives are shown in Appendix 1 for both the new strategy and the previous strategy.

The challenges in the implementation phase of the strategy were related to communications activities, organizational change plans, and usage of internal consultants. First of all, top executives had planned that internal consultants would have facilitated the strategy implementation as change agents in their respective units in 2008. The internal consultants were selected by top executives to convey the strategic message to the organization. In principle, the management of the line organization was not participating in the selection of internal consultants. The selection method raised some suspicion within the organization (Tuominen, 2008). The change agents never had a chance to become active as the strategy implementation came to a halt soon after their nomination.

Secondly, in addition to revision of the strategic objectives and values, the strategy process involved organizational change plans. The organizational plans were an integral part of top executives' strategic process but led to resistance to change. The resistance to organizational change plans decreased the acceptance of strategy as well. Some of the stakeholders felt that too much was done at the same time. See chapter 4.2.5 for more discussion on the effects of organizational change plans.

Finally, communications failed to take different stakeholder needs into account during the strategy process. Especially internal communications was not praised to be successful. Top executives tried to facilitate the implementation by establishing a questions and

answers site to HUS intranet, but most of the interviewed stakeholders concluded that intranet was an inadequate media for this purpose. Such media allowed rumours to breed and opinion leaders to affect the general opinion on their behalf. The questions and answers site was perceived not to provide a true possibility for interactive communication. Lack of such a possibility led for instance to uncontrollable and destructive large-scale email discussions. Face-to-face discussions were not sufficiently organized to ensure acceptance and corrective measures in time. Dialogue within the organization was planned to follow line-organization, but the communication was inconsistent and did not flow as planned. The importance of middle management's role in communicating the strategy internally was not acknowledged. Furthermore, there were no operational strategies to support the overall strategy communication within the organization.

The external communications was not successful either. Message was not tailored for different stakeholder needs and did not ensure information sharing with stakeholders throughout the strategy process. An overall communication plan with stakeholder aspect considerations was not in use. Some of the stakeholder groups such as patient organizations were not informed at all and in the implementation phase many stakeholders grasped the briefing from media and formed an opinion accordingly.

In the late summer of year 2008 the tensions grew out of the bearing limits. The opinion leaders amongst physicians decided to use external media as a tool for strategy opposition. The message conveyed in the media was that HUS was in crisis and suffered from controversial organizational change plans. Especially physicians and university were against the strategy. In the end all the stakeholders, except for the strategy process initiators, namely owners and top executives, rejected the strategy to some extent. The execution of the third strategy came to a final halt in the fall of year 2008.

Many stakeholders agreed that the strategy process had followed a "by the book" methodology. This impression had been strengthened by involvement of an external consultancy firm that was hired to support the top executives in the process. However, according to some stakeholder representatives, usage of external consultancy might have agitated even further the views that top executives were not respecting internal expertise and professionalism. According to these views, a strategy process with external consultants was perceived to promote doctrines from business world and omit the special characters of a health care organization. The annoyance and frustration in the turbulent strategy process is visible in the annual climate survey that was conducted in the end of year 2008. The lowest average score (2,6 in a range of 1 to 5) was recorded for the statement measuring the perceived respect of organizational values from the part of top executives (HUS Personnel Report, 2008).

4.1.2 Strategy revision in late 2008

In September 2008 the CEO concluded that some mistakes had been made in implementing changes to the organization and admitted that further contribution of personnel would be needed. HUS Executive Board decided to appoint an internal investigator to suggest revisions to the management model and related organizational plans. In addition, the CEO was requested to revise the strategic objectives in tight cooperation with personnel.

In the end the strategy revision concentrated mainly on the order of strategic objectives and the related numbering. In fact, personnel were given a wide scale possibility to vote for the order of the strategic objectives. The other updates to the strategy were fairly minor changes to the wordings of the strategic objectives. One of the stakeholders noted that despite of the confusions around the numbering of the strategic objectives in the failed strategy, numbering was in fact needed even in the revised strategy to communicate clearly that stakeholders' concerns on certain perceived priorities were really heard. The main changes in the order of strategic objectives were visible in the focus areas of patients, research and education and personnel. The changes in the order of strategic objectives during a period of 2002 – 2006 are presented graphically in Appendix 2 of this report. The graphics reveal that the order of the focus areas defined in the second strategy was restored in the revision of the third strategy. The revised version of the third strategy was approved in December 2008 for the years of 2009 – 2015.

The participation of personnel and University of Helsinki in the strategy revision process affected the contents of the revised strategy. First of all, after the revision of the numbering, stakeholders perceived that patient centric health care reached the status of a main objective over financial effectiveness objectives. Secondly, the term "customer" was replaced with the term "patient". Thirdly, the revised wordings included a clear expression of respect to personnel. The objective of "clear management model and top class leadership" was replaced with a re-formulated objective of "leadership that supports and values the multi-professional community of experts". Fourthly, the revised strategy mentioned University of Helsinki specifically as a partner for research and education. At the same time the role of owners was mentioned in relation to municipal cooperation instead of transparent governance. Relations with owners were described to be based on cooperation and trust rather than strong governance. Finally, the objective of top world-class research and education was re-phrased to target to high-quality research and education according to the expectations of member municipalities.

After its revision, the third strategy still remained in a general level. No operational strategies were directly derived from the revised strategy to support the overall strategy

communication. The exact wordings of strategic objectives are shown in Appendix 1 for both the revised strategy and the previous strategies.

4.1.3 Acceptance of strategy in 2009

It is striking that many of the interviewed stakeholders reflected their evaluations on the expected benefits of the strategy mainly by analyzing the priorities and order of the strategic objectives in the list of strategic objectives. Choice of such an evaluation criterion may indicate difficulties in seizing the very essence and practical implications of the strategy. Based on this evaluation criterion, the expected benefits of the revised strategy have been accepted by all the stakeholders. However the acceptance is not expressed strongly by any stakeholder group. The impression of acceptance is mainly based on a feeling of status quo. Nobody has expressed strong feelings about the strategy. The general opinion is best characterized by cautious anticipation.

Among the telephone survey respondents of personnel in superior positions 47% thought that the revised strategy was better than the third strategy and 37% were neutral about it. Furthermore, 68% of the respondents felt that the superiors in their departments had committed to the strategy execution. However the respondents remained a bit hesitant whether their subordinates consider the revised strategy better than the previous one. The average score of this statement was 2,9 (below the score 3 for “neither agree nor disagree”) whereas the average score for the statement measuring the assumed opinions of respondents’ superiors was 3,59 (below the score 4 for “partly agree” but above the score 3 for “neither agree nor disagree”). Therefore it can be concluded that the respondents believe that their superiors value the revised strategy higher than their subordinates. The opinion of the respondents themselves scored at 3,47 on average, near the assumed opinion of their superiors.

The general acceptance of strategy is supported by the fact that none of the stakeholders perceive their positions to be directly threatened by the strategy. Furthermore, strategy is found moderately feasible. Changes in the environment (general financial situation) are likely to affect the opinions and increase the likelihood of acceptance as people understand that resources are scarce and efficiency is required. In addition, the current general financial situation and changes in it affects stakeholder’s opinions about the suitability of the strategy. However owners find that structural changes are needed in order to ensure that the strategy is suitable in the current environment. Furthermore, representatives of municipal health centres and patient organizations share concern of the fact that suitability has not been supported by collaboration in situation and environment analysis between HUS and the concerned parties.

Top executives expect that the line-organization will take care of the implementation of the revised strategy. An overall program for the strategy execution has not been planned. However according to top executives there are several ongoing projects and plans that are in line with strategic objectives and can be considered as actions to implement the strategic objectives in specific areas of operation. According to the telephone survey data personnel in superior positions are well aware of the fact that the strategic objectives were updated in the end of year 2008. This statement scored highest at 4,68 in the telephone survey. However the general stakeholder perception is that the strategy remains to be executed. The stakeholders are in an awaiting mode. This situation is reflected even in the telephone survey results showing that as many as 23% of the respondents couldn't say how their own superiors felt about the new revised strategy compared to the previous one. It seems that the internal discussions on the current strategy have not been active in all levels. Still 40% of the data survey respondents said that the strategy has taken off well compared to a share of 18% for pessimistic views.

4.2 Comparing the different stakeholder points of view

In the beginning of this chapter, the views on the subject matter commonly shared by all the stakeholders are explained. Then the distinct views of different stakeholders are described in more detail in the subsections of this chapter.

The commonly shared views show that all the stakeholders agree that strategy is essential for managing an organization such as HUS. For instance in the telephone survey 92% agreed on that "it is important, that HUS has a strategy". Revision of the strategy every fourth year is a fundamental part of the existing governance system. Many stakeholders agree that strategy should be checked even more often. Evaluation of environmental changes and their implications to the strategy should be more of a continuous process.

Despite of the fact that almost all the stakeholders were involved to certain extent in the strategy process, all the stakeholders would have liked to participate even more. However for instance patient organizations acknowledged that wide participation scheme might make the strategy process too heavy to conduct.

All the stakeholders thought that supportive operational strategies are needed for implementing the overall strategy. According to this shared belief, overall strategy can't be implemented as such. However one stakeholder representative claimed that the overall strategy might serve as a priority list in decision making de facto.

Most of the stakeholders perceived all the recent strategies of HUS to be very similar and general in nature. Many interviewees reflected that the strategic objectives actually

describe the fundamental duties and tasks that HUS has operated ever since its establishment. Some of those operations are derived directly from the organization's legal duties. The lack of more precise corporate level strategic objectives is likely to hinder creation of operational strategies based on the corporate level strategic objectives.

A majority of the interviewed stakeholders thought that numbering of the strategic objectives affected the acceptability of the failed strategy. Many of the stakeholders perceived the numbering as a priority list. However some stakeholders said that they personally do not find the numbering to be an important factor. Furthermore it was said that even the order of strategic objectives (without numbering) affects the perception of priorities. Top executives said that numbering was not meant to be a priority list in the first place, but as reported, it was commonly interpreted to be a priority list in the end. This impression was strengthened by internal communications that was perceived to emphasize the importance of the financial objective over other strategic objectives. One of the interviewees concluded that the objections towards the order of strategic objectives were an expression of otherwise dissatisfied stakeholders, especially personnel, who were opposed to certain plans in relation to the strategy process (see chapter 4.2.5 for further explanation). According to this point of view, numbering as such wasn't an ultimate factor affecting the acceptability of the strategy.

All the stakeholders more or less agreed that the current strategy is fairly feasible and suitable to the current operating environment. The challenges brought up by the stakeholders were all related to the factors affecting strategy acceptance.

All the stakeholders remain hesitant in forecasting any future success of strategy execution at HUS. "A big ship turns slowly" commented some of the interviewed stakeholders. This kind of outlook among the stakeholders seems to have been prominent throughout the strategy process.

4.2.1 Customers

In the terminology of this report, the stakeholder group of customers refers to both patients and municipal health centres. Patients are represented by patient organizations.

Patient organizations did not participate in the strategy process. Top executives did not ask them to participate as they thought that patient organizations are primarily for safeguarding the patient interests in individual cases. The interviewed representatives of patient organizations mentioned that the organizations would have useful patient related information to share with HUS in a strategy process. Furthermore, patient organization representatives pointed out that a patient centric strategy such as the revised HUS

strategy would naturally invite participation from patient organizations. Still these organizations have never had a chance to actively participate in the strategy process of HUS.

The interviewees from municipal health centres represent not only customers but also owners in the network of key stakeholders. Therefore some of the viewpoints of these representatives are discussed in the subsection describing owners' points of view (chapter 4.2.3). Regarding information sharing for environment screening purposes the municipal health centre representatives shared the aspirations of patient organizations. Health centres have a multitude of relevant information to share with HUS in the name of common strategic health care planning.

4.2.2 Partners

In the terminology of this report, the stakeholder group of partners refers to both the University of Helsinki and labor unions.

University of Helsinki had had a strong role in the process of defining the strategy for the years of 2006 – 2015. That specific strategy was still unimplemented in 2007. Therefore University of Helsinki did not detect a need for strategy renewal as such. The university has strong connections to an internal stakeholder group of personnel that strengthen its power to affect HUS strategy as a stakeholder group (Johnson et al. 2008). The internal connections are reflected for instance in a mutual understanding that Chief Medical Officer of HUS represents the expectations of university within the HUS organization. The role of Chief Medical Officer amongst top executives changed during the analyzed strategy process, which has affected the perceived influencing possibilities of the university as well. University of Helsinki adopted an active role in the revision of strategy late 2008. The objective was to safeguard the position of research activities in the list of strategic objectives. Furthermore, the central position of Chief Medical Officer as a member of HUS Executive Group was restored.

Trustees from labor unions participated in the strategy process. In addition, the top executives of HUS kept the central offices of labor unions informed of the progress in the strategy process. The role of labor unions was visible especially in safeguarding the employees' interests during the process of organizational changes with role modifications.

4.2.3 Owners

For this research, the current and previous chairmen of HUS Executive Board were interviewed as representatives of owners. In addition, the interviewed municipal health

centre officers represent not only customers but also two of the largest member municipalities.

The representatives of member municipalities in HUS Executive Board and HUS Council are politicians selected by regional branches of political parties. The largest member municipalities have publicly suggested that they should have the power to select representatives of owners to HUS Executive Board themselves (Kuntalehti 1/2009). Some of the interviewed stakeholders found the political governance model to hinder the openness and activity of communication between HUS and municipal officers. In fact, an interviewed representative of HUS Executive Board found it important that in the future municipal officers would be allowed to review and comment the strategy prior to its approval by HUS Council.

It is to be noted that the HUS Council acting in its 4-year-term of operation in 2005 – 2008 has approved all the strategies of HUS except for the very first one. Accordingly, the respective HUS Executive Board has supervised the conduction of three strategy processes at HUS in a comparatively short period of time. The explanation for the exceptionally high frequency of strategy renewal arises from the endeavours to balance stakeholder expectations, especially those of owners and personnel, in strategy formulations. The result of balancing between the expectations of owners and personnel has led to perceived similarities between all the recent strategies. From the strategy process point of view, HUS Executive Board has had a central role in prioritizations of different stakeholder perspectives through their strategic guidance.

Even that the political representatives of member municipalities in HUS Executive Board were active drivers of the strategy process the overall participation of owners in the strategy process remained limited. The owners had their expectations initially high as they had made their overall objectives very clear as starting points for strategy formulation. But the existing governance model kept the municipal officers at arm’s length during the actual strategy process. The member municipalities were kept informed of the progress throughout the strategy process but neither municipality officers nor mayors were actively participating in the process after its initiation. Indeed many of the interviewed stakeholders were concerned about the fact that there has been very little proactive cooperation in the area of strategic planning between specialized medical care (arranged by HUS for the owner municipalities in its area of operation) and primary health care (organized by municipalities themselves). At the same time the two are expected to join their forces in the area of strategic planning as a reaction to the new Health Care Act at the latest. In fact, it was suggested in the interviews that the multi-role of municipalities as owners and customers of HUS would be better handled on a partnership basis within the stakeholder

scheme of HUS. A partner approach would improve the possibilities to reach the goal of maximizing value for patients in full cycles of care.

4.2.4 HUS top executives

There was concern among top executives that involving all the stakeholders in the strategy process might lead to a higher risk of hesitancy in leading the strategic change. At the same time top executives admit that strategy acceptance requires participation from all key stakeholders. Top executives identify personnel and University of Helsinki as primary agents to participate with top executives in the process of strategic planning. These very stakeholders were the ones to participate in the revision of the third strategy late 2008. In addition, top executives acknowledge the central role of owners as strategy acceptors in the decision making bodies of HUS.

Top executives felt that the overall expectations of different stakeholder groups were clear for them. From the perspective of top executives, only the expectations of personnel concerning the possibilities to participate in the strategy process were not identified well enough after all. Top executives believe that would they have detected these desires to participate, the strategy wouldn't have been destined to fail in 2008. Furthermore, many stakeholders claimed that the strategic objectives were vague and general in nature. Such an observation may indicate that the actual specific stakeholder expectations in the given circumstances have been difficult for top executives to recognize.

Top executives consider strategy to be a tool of top management. Therefore the strategy is strongly personified to top executives. According to some stakeholders many within the personnel think that strategy is "something that administration plans and does". It is not seen as a joint agenda or effort within the organization. This impression has been intensified by the fact that in addition to the newly appointed CEO, the deputy managing director in charge of the strategy process was originally from outside the health care sector and accepted a visible role in the strategy process while arousing controversy within the organization.

4.2.5 HUS personnel

The strategy for the years of 2006 – 2015 was relatively recent. Therefore in 2007 personnel did not detect a need for strategy renewal as such. Furthermore, personnel did not adopt the financial rationale for the strategy renewal. In fact the commonly referred understanding among personnel was that HUS was already successful in both national and international efficiency comparisons. Therefore personnel did not buy the need to initiate a strategy process as such. Among the telephone survey respondents only 50% of

nursing staff and 27% of physicians thought that the grounds for the new strategy were clear and recognized by personnel.

Top executives invited personnel to participate in the strategy process in 2007 by selecting representatives of personnel based on their positions in the organization. Top managers of the line organization were involved. In addition trustees of labor unions were expected to represent personnel in the strategy working groups. Top executives believed at the time that involving the chosen representatives would ensure the required strategic discussion with personnel, but afterwards the top executives suspected that these representatives didn't have the required wide scale mandate from personnel to represent them in the strategy process. Specifically, there was a lack of support to the chosen personnel representatives from the part of opinion leaders. The opinion leaders' did not find this representation to be sufficient in discussing the strategic expectations of personnel during the strategy formulation. Furthermore, some stakeholders claimed that the representatives of personnel failed to convey the information flow between top executives and personnel. In consequence, top executives did not detect the early signs of tensions within personnel (HUS Audit Board Report, 2008).

The third strategy process did not originally ensure participation of opinion leaders as such. In the interviews, some stakeholder representatives assumed that opinion leaders among physicians might have been sceptical about the actual implementation of the third strategy, which might have affected their motivation to participate initially. This notion gets further support from the telephone survey data that only 58% of physicians think that HUS can be steered by the means of a strategy whereas 94% of the nursing staff sees these possibilities positively. However during the strategy process it became evident for the opinion leaders that the strategy would have direct implications in the operational level, which activated expressions of indirect power from their part. In the interviews, many stakeholders referred to a group of influential "star physicians" that were not heard when preparing the failed third strategy in 2007 and 2008.

The top executives did not foresee this indirect power and high level of influence of opinion leaders within the organization. According to top executives this was one of the main reasons for the failure of strategy in 2008. The opinion leaders of influential physicians can affect the general opinion through media, politicians, and internal discussions. This scenario was realized strikingly in the late summer of 2008, when these opinion leaders used media for getting support to their views. Many stakeholders said that the appearance of opinion leaders in media and public forums had a negative impact on the overall strategy acceptance within the organization. After these events the opinion leaders were requested to participate in the strategy revision late 2008. However the position of opinion

leaders to represent personnel remains controversial. According to the telephone survey data, only 18% of the physicians in superior positions and 10% of nurses in superior positions agree that opinion leaders represent well the true opinions of personnel.

According to many stakeholders the commonly stated perception among personnel is that personnel did not have a true possibility to participate in the third strategy process. The statement of “in my opinion, personnel could say their opinion in the preparation of HUS strategy” reached the lowest average score of 2,54 in the telephone survey corresponding to a value between “partly disagree” and “neither agree nor disagree”. This perception prevails even after the revision of the third strategy. Only 32% of the respondents felt that the current strategy is an outcome of a collaborative effort between top executives and personnel. Also, the telephone survey data confirmed the notion that the selection of representatives plays a crucial role when ensuring the participation. Many stakeholders concluded that not all the people can be heard but representatives should participate. Therefore special attention should be paid to the selection of representatives for ensuring that they possess the required mandate and communication channels to personnel. In fact, the respondents of the telephone survey thought that personnel in superior positions would be suitable representatives of personnel in the strategy process. 84% of the respondents thought that they as superiors have an impact on their subordinates’ opinions about the strategy. The respondents were more sceptical about the ability of opinion leaders and trustees of labor unions to represent personnel in the strategy process.

The challenges with the channels of internal communication contributed to the feeling that personnel’s opinions were listened but not heard. Communication problems between top executives and middle management were recognized and there were mutual feelings of “speaking different language”. Many stakeholders reckoned that personnel perceived the strategic dialogue to be commanding and dictating in nature. A feeling that top executives would have pre-determined the contents of the third strategy irrespective of the actual strategy process was mentioned in a couple of interviews. Furthermore, the stakeholders commonly perceived that there weren’t enough face-to-face encounters for facilitating a dialogue between top executives and personnel in practical terms of operating the strategy. Such a dialogue especially between top executives and middle management would have been needed to ensure acceptance of strategy among personnel. Dialogue within the line-organization as such is not enough to ensure commitment at all required management levels. In fact, some stakeholders considered the hierarchy of the organization to cause some additional challenges. As pointed out by Johnson et al., organizational hierarchy is likely to strengthen personnel’s power as a stakeholder group (2008).

64% of the telephone survey respondents in superior positions within HUS believed that their departments are prepared to plan and execute operational level strategies. Also most of the interviewed stakeholders thought that middle management has the required capability to execute strategy. Some stakeholders referred to the employees' professionalism in substance oriented teamwork and concluded that such a teamwork spirit is something that is required in strategy execution and leadership as well. Still there was concern among some top executives that there might be issues to solve in leadership skills and motivation of middle management.

Some stakeholders pointed out that personnel felt that their professionalism was not respected as the new HUS Executive Group (operative top executives) in 2008 excluded physicians and nursing staff. Also the plans to replace the existing job titles of Chief Physician and Chief Nurse with the titles of Service Manager and Resource Manager were strongly opposed by both physicians and nursing staff. Many felt that the new job titles expressed business management culture, not culture of a health care organization (HUS Audit Board Report, 2008). This was another reason for personnel to feel offended about a breach of professionalism. Furthermore, many stakeholders believed that physicians were offended because they felt that their substance was not respected during the strategy process in 2007 and 2008. Specifically, there were fears among physicians that their position or duties would have been affected negatively by the failed strategy. This view was mainly derived from the organizational change plans that were perceived to weaken physicians' status and have negative impact on job requirements. On the other hand, according to some stakeholders these very organizational plans might have had a positive impact on nursing staff's position in the organization, if implemented as first planned. The revision of strategy and organizational plans ensured that the positions of both physicians and nursing staff were neither threatened nor improved but kept in fundamental parts the same.

Based on both the interviews and telephone survey it is evident that the planned organizational changes affected considerably the acceptability of the third strategy among personnel. Only 14% of the respondents in the telephone survey thought that the organizational change plans didn't have any effect on the strategy acceptance. It seems that personnel were prone to consider organizational adjustments as a manifestation of the third strategy. From this point of view it is evident that it would have been utterly important to discuss the organizational change plans with personnel. Also, the financial objective attracted a lot of attention in the implementation phase of the third strategy, because personnel perceived patients and research to be of lower priority in the list of strategic objectives. In addition, many got annoyed simply of the fact that the failed strategy referred

to “customers” rather than “patients”. This was perceived to disrespect the core mission of the professions – to provide patients with care.

HUS is a young organization and it is quite natural that personnel still feel closer to their working units and hospitals. In fact, 56% of the interviewed staff members in superior positions felt more close to their own units rather than HUS as a whole. There are a lot of borders within the HUS organization and many of the strategic changes (and related organizational changes) have involved cross-border initiatives. Top executives admitted that this is a challenge when executing overall HUS level strategy. However stakeholders did not identify personnel’s loyalty to one’s own unit (rather than commitment to HUS as a whole) to have been among the main reasons for the failure of strategy in 2008. Some stakeholder representatives even said that preference of unit level commitment could be seen as a positive possibility in strategy execution.

Finally, there are differing views on organization’s general readiness to change. Some stakeholder representatives said that the organization is conservative and there is not a good track record of accepting changes within the organization in general. On the other hand some stakeholders expressed that the organization is capable to change providing that professions are not threatened and change management is successful. In the telephone survey, 50% of the respondents believed that the general opinion in their departments is favourable to change. At the same time it has to be noted that 92% of the respondents thought that strategy as such is important for HUS and the general attitude towards strategic development among respondents was positive.

Summaries of telephone survey results are shown in Appendix 11 of this report.

5 Analyses and results

In this chapter the findings are reflected to the chosen theoretical framework. The outcomes of these analyses are described as results. The purpose of this chapter is to reveal the identified reasons for failure of strategy in 2008 and suggest the key success factors for future strategy execution accordingly.

5.1 Reasons for failure of strategy in 2008

According to stakeholder theorists an organization succeeds in its strategic endeavours only if perspectives of all key stakeholders are integrated in the strategy (Freeman et al. 2001, Johnson et al. 2008). Therefore the main hypothesis of this project is that the strategy of HUS failed in 2008 due to the insufficient levels of strategy acceptance among

stakeholders. The data analyses have been focusing on gathering supportive data to reveal, whether this has been the case in practice.

Johnson et al. argue that success of a strategy depends on three factors, namely suitability, feasibility and acceptability of strategy (2008). Furthermore, strategy acceptance is an outcome of multiple factors. First of all, stakeholders are more likely to accept the strategy if they perceive it to be suitable and feasible in the existing operating environment. Any perceptions of unsuitability or infeasibility may have a negative impact on the strategy acceptance. Furthermore, execution of strategy imposes an organization to a prospective change. Therefore any issues enforcing challenges to change may have a negative impact on the strategy acceptance. According to the model of Peltokorpi et al. the following factors need to be evaluated for detecting any challenges to implement change: (1) capability to change, (2) effect on stakeholders' actions and position, (3) influencing possibilities, (4) goal clarity, (5) change complexity, and (6) management capability (2008). In addition, the special characteristics of health care organizations need to be understood when identifying any challenges to implement changes according to the factors in the model of Peltokorpi et al. (Parvinen et al. 2005, Peltokorpi et al. 2008).

Based on these criteria a set of underlying factors can be found for the failure of the original third strategy in 2008. The stakeholders were opposed to the strategic change due to the following underlying reasons:

(1) Organization's capability to change was weakened. In addition to the strategic change, top executives tried to change the prevailing organizational culture at the same time by introducing a new management culture with less expressions of respect to professions.

(2) Stakeholders foresaw the strategic change to have undesirable effects to their positions. Especially physicians feared that they would forfeit some of their key positions within the organization. This impression was derived from the organizational change plans and was further strengthened by the perception of financial effectiveness prioritized over patients, education and research.

(3) Strategy process did not enable the expected influencing possibilities for key stakeholders. Firstly, stakeholders generally expect a more collaborative approach. For instance external stakeholders would have liked to contribute to the environment analysis of the strategy process. Secondly, some challenges were perceived in the role of participating stakeholder representatives as strategy process facilitators within their respective stakeholder groups.

(4) The goals of the strategic change were not clear. The necessity to change was not implicit for personnel. Motivation to change was not inspired by an articulation of a vision in a manner that stresses the values of personnel. Strategic change promoting financial effectiveness as such is bound to face barriers in a health care organization such as HUS, where effectiveness should be an outcome of value bringing patient care rather than an objective as such.

(5) The changes required in the organization to execute strategies were found complex. There were no operational level strategies of practical importance for personnel to concretize the objectives of the overall strategy, which left the strategy difficult to digest in the operational level. Also, the perceived challenges in balancing between competing expectations of various stakeholders strengthen the impression of difficulties to prioritize according to strategy.

(6) Stakeholders perceived challenges in both internal and external dialogue. Internally, the chosen communication channels did not succeed in conveying the required information in a constructive and truly interactive manner. The internal communication model did not promote empowerment and involvement of middle management in achieving commitment to the strategy in the whole organization. Motivation of middle managers to discuss the strategy with their subordinates was compromised. For external stakeholders, there was no specific communication plan for involving them throughout the strategy process for stakeholder acceptability assurance.

In addition to the aforesaid factors identified according to the model of Peltokorpi et al., yet another underlying factor emerges, namely (7) pace of change:

(7) The strategy process was not conducted at a pace that would have been adjusted to overcome the detected challenges. Time not taken to listen and process the strategy according to the expectations of the stakeholders deteriorate the possibilities to succeed in assurance of capability to change, goal clarity, stakeholder participation and other areas of key importance in the strategy execution.

All of these identified factors led to insufficient stakeholder acceptability, which was the utmost reason for the failure of the strategy. Neither suitability nor feasibility as perceived by stakeholders was causing the strategy failure. The strategy was rejected explicitly among the stakeholder group of physicians supported by University of Helsinki. In addition, external stakeholders would have preferred more collaboration during the strategy process.

From a strategy acceptance point of view it is crucial, whether key stakeholder consider the strategy process a collaborative effort or an undertaking of selected individuals. The interviews revealed that despite any top executives' aspirations to ensure a sufficient participation from selected stakeholder groups, all the other key stakeholder groups regarded the strategy process to have failed in reaching the results by the means of a collaborative effort. Many interviewees pointed out that participation as such is not enough but it is the perceived opportunities to truly affect the formulation of the strategy that counts. This requirement is challenging to fulfil in a multi-stakeholder scheme of HUS, where not only balance in stakeholder expectations need to be governed but also a suitable model for representation of stakeholder groups need to be created. It is of great importance not to assume without careful stakeholder consultation that certain individuals hold the required mandate to represent a stakeholder group in a strategic dialogue.

5.2 Success factors from stakeholder perspective

The success of the revised strategy and future strategies at HUS will depend on the organization's ability to address the identified challenges with the strategy in 2008. Therefore the success factors for the execution of the revised strategy are as follows:

(1) Supporting the organization's capability to strategic change by respecting the existing organizational culture with strong professions.

(2) Cooperating with stakeholders especially in case of plans that are likely to affect their position or duties.

(3) Providing the stakeholders with influencing possibilities by active stakeholder management. For instance municipalities would be best handled as partners to collaborate with. Stronger participation of municipalities and patient organizations in environment analysis would enhance a coordinated approach to strategic management of health care. Furthermore, selection of representatives from each stakeholder group would need to be based on true mandates for ensuring appropriate dialogue between the stakeholder group and the strategy process.

(4) Making the goals of strategy execution clearer than ever for all the key stakeholders. Personnel should be given reasons to execute strategy according to a vision that is articulated for them in a manner that stresses the values of the whole organization. Justification for the need of strategic change should be demonstrated with meaningful data showing the benefits of executing the strategy.

(5) Limitation of change complexity by organizing a program for setting up a clear set of operational strategies that are derived directly from the overall HUS strategy. Promotion of shared stakeholder interests for communicating a common vision to

strive for instead of emphasizing competition between different stakeholder expectations.

(6) Ensuring commitment of middle management and key stakeholders by paying extra attention to proactive internal and external dialogue. Different stakeholder expectations should be addressed in an overall communication plan with stakeholder specific dialogue schemes covering all the phases of the strategy process. The dialogue should especially involve empowering middle managers as essential agents of strategic management.

(7) Adjusting the pace of change to the organization's capability to change. Although strategic changes should be implemented as quickly as possible for reaching the incorporated advantages, listening to the feedback and adjusting the pace is called for to secure acceptance and commitment among key stakeholders.

Assuming feasibility and suitability of upcoming strategies, the success of the future strategies of HUS will depend on the organization's ability to attract a sufficient level of strategy acceptance from its key stakeholders. Capturing the key success factors identified herein will be crucial in the organization's endeavours to reach the required strategy acceptance levels.

5.3 Summary of results

Strategy failed in 2008 due to insufficient stakeholder acceptability. A set of reasons for the lack of stakeholder acceptability was detected from the interview data. Success of the revised strategy will depend on the organization's capability to address the issues that have had a negative impact on the stakeholder acceptability.

The challenges to implement change in relation to the factors of capability to change, effect on stakeholders' actions and position, influencing possibilities, goal clarity, change complexity, management capability, and pace of change have had inevitable consequences in the stakeholder acceptance of strategy. The acceptance was especially weak among physicians, which was reflected to the overall acceptability and viability of the strategy. Many of the challenges to change were partly related to the distinctive characteristics of health care organizations with strong professions. Specifically, in such an organization capability to change requires support of the existing organizational culture that is to be respected accordingly.

6 Discussion and evaluation of research

In this chapter the findings are further discussed and evaluated to provide recommendations and suggestions for future research.

6.1 Discussion

HUS has introduced three new strategies in a three years time. The chain of strategies is an outcome of reactive management of influences derived from various stakeholder expectations. Since the expectations of stakeholder groups tend to differ, top executives need to adopt a goal oriented stakeholder management approach for balancing the multiple stakeholder relationships, objectives and values in the strategy process. At HUS, proactive approach to stakeholder management throughout the strategy process is yet to be developed and strengthened as a fundamental source for strategy acceptance. The top executives' ability to make right evaluations on the organization's key stakeholders and their expectations is crucial for the overall success of strategic management. Motivation of strategy acceptance from each stakeholder group within an active stakeholder management scheme should be based on these careful evaluations.

Active management of various stakeholder expectations is a necessity for a public health care organization that has a number of key stakeholders with diversified goals to reach. The importance of stakeholder management is especially high in organizations with governmental and political guidance. Specifically, the role of board in strategic management needs to be fully understood for managing and balancing the different stakeholder interests beyond the political governance model. The existing political governance model at HUS is not stimulating an integrated approach for municipal officers and HUS to develop the whole health care system in strategic partnership. Lack of such an approach means missed opportunities of bringing even better value for patients. Distinct strategic management of primary health care and specialized medical care does not support alignment of strategies to bring value for patients in the full cycles of care. This misalignment is a substantial generator of additional tension between the stakeholders in the formulation and execution of HUS strategy. It is also a source of inability to strive for innovative approaches in strategic thinking beyond the existing structures and practices.

Refraining from innovative strategic choices results in descriptive strategic objectives and perceived lack of goal clarity among stakeholders. The goals should be meaningful for each stakeholder group. The stakeholders are more likely to commit to strategic change if the new direction is found to support the organization to grasp new opportunities and meet

the challenges and expectations in the operational environment. The strategy needs to spell out not only description of existing operations but strategic choices with practical relevance for each stakeholder group.

A successful strategy process lets the key stakeholders to participate and influence the strategic thinking of the organization. The influencing possibilities are especially crucial in an organization with strong professions and powerful stakeholders. In addition, top executives need to respect the existing organizational culture to facilitate the organization's capability to change according to the requirements of the strategy. A "walk the talk" management style is a necessity. Mutual understanding in the stakeholder network needs to be based on trust and respect for the existing capabilities in the organization and stakeholder network. Specifically, without the commitment from the organization and especially middle managers introduction of any major changes is doomed to face resistance that is utterly difficult to overcome. Still, from the perspective of personnel, the importance of middle management's role seems to be highly underestimated in the strategic management of HUS. The middle managers should be given every appropriate possibility to contribute in the execution of the strategic objectives within the organization. Training in leadership skills is a potential source for further successes in this area. Also, the representation of personnel in strategy process needs to be reviewed and planned to meet the expectations of the personnel as a whole. In addition to the physicians' central role, University of Helsinki remains a crucial partner for HUS in assurance of the success in execution of future strategic efforts in the organization.

A partnership model in cooperation between primary health care and specialized medical care would need fundamental commitment in the governance of strategic management in Finnish health care. It remains to be seen, whether health care organizations adopt a more active role as strategy executors and innovators after years of reactive strategic planning according to the general governmental guidelines. The current financial turmoil will evidently push the organizations to distinctive approaches in their strategic thinking due to tightening municipal finances and increasing share of elderly population. In addition, the upcoming new health care legislation is also likely to encourage adoption of new strategic approaches.

From the perspective of HUS, the fragmented and diversified organization makes the implementation of a common strategic management model more complicated but as pointed out in the Kaiser Permanente example of this report, strategy execution can be successful even in health care organizations with multiple hospitals and departments in multiple regions. The strategy of Kaiser Permanente promotes true strategic choices such as integration of electronic medical records, establishment of multi-disciplinary integrated

practice units, and coherent cooperation between primary health care and specialized medical care. As common for strategies of Finnish hospital districts, the strategy of HUS is based on another kind of approach, where rather self-evident existing functions of the organization are described in a broad level. Formulation of practical strategic objectives would express the organization's capability to make true strategic choices required to ensure goal clarity in the eyes of key stakeholders. Such clear goals contribute to the overall stakeholder acceptability of strategy. Furthermore, compared to the Kaiser Permanente strategy execution, the ownership structure of HUS creates some additional complexity for the implementation of the strategic management model. Larger and smaller municipalities obtain somewhat different expectations that need to be balanced in the overall stakeholder management scheme.

Finally, according to HUS Audit Board Report, the turmoil of year 2008 has made the management of the joint authority to appear unsatisfactory (2008). The HUS Audit Board calls for improvements in openness and revision of policies and points out to the challenges of political governance. The multi-level political decision making model is found to impose an extensive liability for those presenting and preparing matters for the elected decision making bodies. Therefore HUS Audit Board has expressed its intentions to pay extra attention to the role and operations of HUS Executive Board. The auditors conclude that the existing knowhow of the organization needs to be taken advantage of in reformation of the existing structures of the organization (HUS Audit Board Report, 2008). These very insights of the HUS Audit Board support the findings of this research.

6.2 Relevance and validity of this research

The findings of this research are to be found relevant for assessment of stakeholder acceptability of strategic changes in a health care organization with strong professions, political governance model and powerful stakeholder network. Based on the evaluations of this research, the applied framework can be found useful in evaluation and facilitation of change processes in similar contexts. The selected theoretical framework has proven useful not only in this research but in another study as well (Peltokorpi et al., 2008).

The selected research methods, namely semi-structured interviews and telephone survey, proved to be fairly appropriate means of collecting data for the purpose of this research. The findings from semi-structured interviews were confirmed by the data from telephone survey. Still caution is needed when generalizing the research findings to the level of entire stakeholder groups. The semi-structured interviews were conducted by interviewing discretionally selected representatives from each stakeholder group. The interviews may have been affected by the interviewees' personal opinions. However this phenomenon was controlled to some extent by verifying the perceptions from other sources (telephone

survey, other interviewees or supportive documents such as HUS Audit Board Report 2008). The telephone survey was targeted to the HUS personnel in superior positions only with a limited sample size. The statistics calculated from the sample data serves as an indicative review of the perceptions among the employees in the sample, but does not represent the state of affairs in HUS personnel or middle management as a whole. However the results combined with the findings from the semi-structured interviews serve as a good indicator of the personnel's perceptions on the subject matter.

According to the knowledge of the research group, this research has been the first effort to evaluate the strategy process of HUS from a holistic point of view that takes all the key stakeholders into consideration. The research group wishes that the practical relevance of this research would be recognized in the organization's future strategic development efforts.

6.3 Suggestions for further research

This research was to deepen understanding of strategic management challenges in organizations with strong professions and multiple powerful stakeholders in the context of Finnish health care sector. In this chapter some suggestions for further research are provided.

First of all, it could be of great interest to verify the applicability of the research findings in other health care organizations facing strategic changes. The adoption of the suggested framework and comparison of findings could provide a means of facilitating a strategy process in another organization facing the complexity of expectations within the stakeholder network. This applies even to organizations in other industries with strong professions and tensions between governance and substance orientation. Examples of such organizations in other industries include airlines with a strong profession of pilots and companies governed under an active state ownership policy. The impact of the strong professions and political governance on an organization's capability to execute strategic changes would be of interest in this context. Also, it could be beneficial to study the performance of stakeholder mapping tools in assurance of best practices in management of multiple stakeholders to avoid conflicts and improve stakeholder acceptability during strategic change processes.

Furthermore, as suggested in this report, Finnish health care organizations could adopt an active role in redefinition of their strategies. The strategic choices recommended by Porter et al. require seeking of new innovative ways to cooperate over organizational and municipal borders. Evaluation of Finnish health care organizations readiness to adopt and execute the required strategic changes remains in great interest. Specifically, it would be

of interest to evaluate the success factors of a partnership model in strategic cooperation between primary health care and specialized medical care.

6.4 Conclusions and recommendations

It is to be noted that the basis for execution of the revised strategy is better compared to the failed strategy due to the following reasons:

1. Personnel trust Chief Medical Officer to act on strategic initiatives. Personnel trust that the existing organization culture is respected.
2. Organizational change plans were modified according to the wishes of personnel.
3. Wider selection of personnel representatives was participating in the strategy revision process. Thus the influencing possibilities have been improved.
4. General financial situation makes the controversial strategic goal of balanced finances more understandable for all the stakeholders. The public discussion has urged the organization to understand the importance of strategy for HUS.
5. So far, none of the stakeholders have expressed striking controversial views on the revised strategy. The strategy acceptance seems to be in a level that further execution is possible. Middle management is open for dialogue to execute the strategy by the means of supporting operational level strategies.
6. The ongoing changes in the operating environment, not least the preparation of the new Health Care Act (Memorandum of the Working Group Preparing the Health Care Act, 2008), justify introduction of any new strategy and would support any efforts to clarify the goals and need of strategic change for all key stakeholders.
7. The process of revising the third strategy provided the organization and the stakeholders with the required extra time to reduce anxiety and improve strategy acceptance.

Bearing in mind these assisting factors it is recommended that further strategy execution at HUS is advanced by seeing to management of the issues that had a negative impact on the stakeholder acceptability in 2008. Success of the strategy requires stakeholder acceptability, which can be supported by eliminating the challenges to change. Stakeholders are more likely to accept the strategy, if the existing organizational culture is respected and cooperation with stakeholders is strengthened especially in matters that affect the stakeholders' position or duties directly. Furthermore, active stakeholder management should involve proactive partnership approach and transparency in selection of representatives from each stakeholder group. All the key stakeholders should share a

common understanding that there is an evident need to change through strategy execution. The communication throughout the strategy process should be based on a communication plan that takes different stakeholder needs into account and promotes dialogue in an ethos of mutual collaboration. Specifically, involvement of middle managers is required to ensure the commitment in an organization level.

Finally, it is recommended that a program would be activated for setting up a clear set of operational strategies that are derived directly from the overall HUS strategy. Concretizing the purpose and consequences of the strategy to an operational level is a necessity to reach full acceptance of the strategy. Internalization of the current strategy is a key to success of future strategic initiatives and development at HUS. Adoption of a strategic approach to development in health care is essential for an organization that wants to be not only responsive to environmental changes but proactive in reformation of health care sector.

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Appendices

The following appendices are attached to and incorporated into this report:

Appendix 1. Strategic objectives of HUS in a period of 2002 – 2009.
Appendix 2. The changes in the order of strategic objectives in a period of 2006 – 2009.
Appendix 3. Comparing the strategic objectives of university hospital districts in Finland.
Appendix 4. Kaiser Permanente in brief.
Appendix 5. Strategic choices of Kaiser Permanente compared to Finnish health care.
Appendix 6. List of conducted semi-structured interviews.
Appendix 7. Predefined questions of semi-structured interviews.
Appendix 8. List of superior job titles for telephone survey.
Appendix 9. Description of interviewed employees in a summary level.
Appendix 10. Statements and answer alternatives presented in the telephone survey.
Appendix 11. Results of telephone survey for HUS personnel.
Appendix 12. Milestones of the business project.

Appendix 1. Strategic objectives of HUS in a period of 2002 – 2009.

1st strategy (2002 – 2010)	
Focus area	**Strategic objective in English**
Customers	*Various objectives concerning customers and patients with specific objectives concerning cooperation with primary health care*
Processes	*Various objectives concerning processes and research with specific objectives concerning IT enabled health records to be shared with primary health care*
Personnel and leadership	*Various objectives concerning personnel, education and leadership*
Finances	*Various objectives concerning finances (cost effectiveness) and structures*

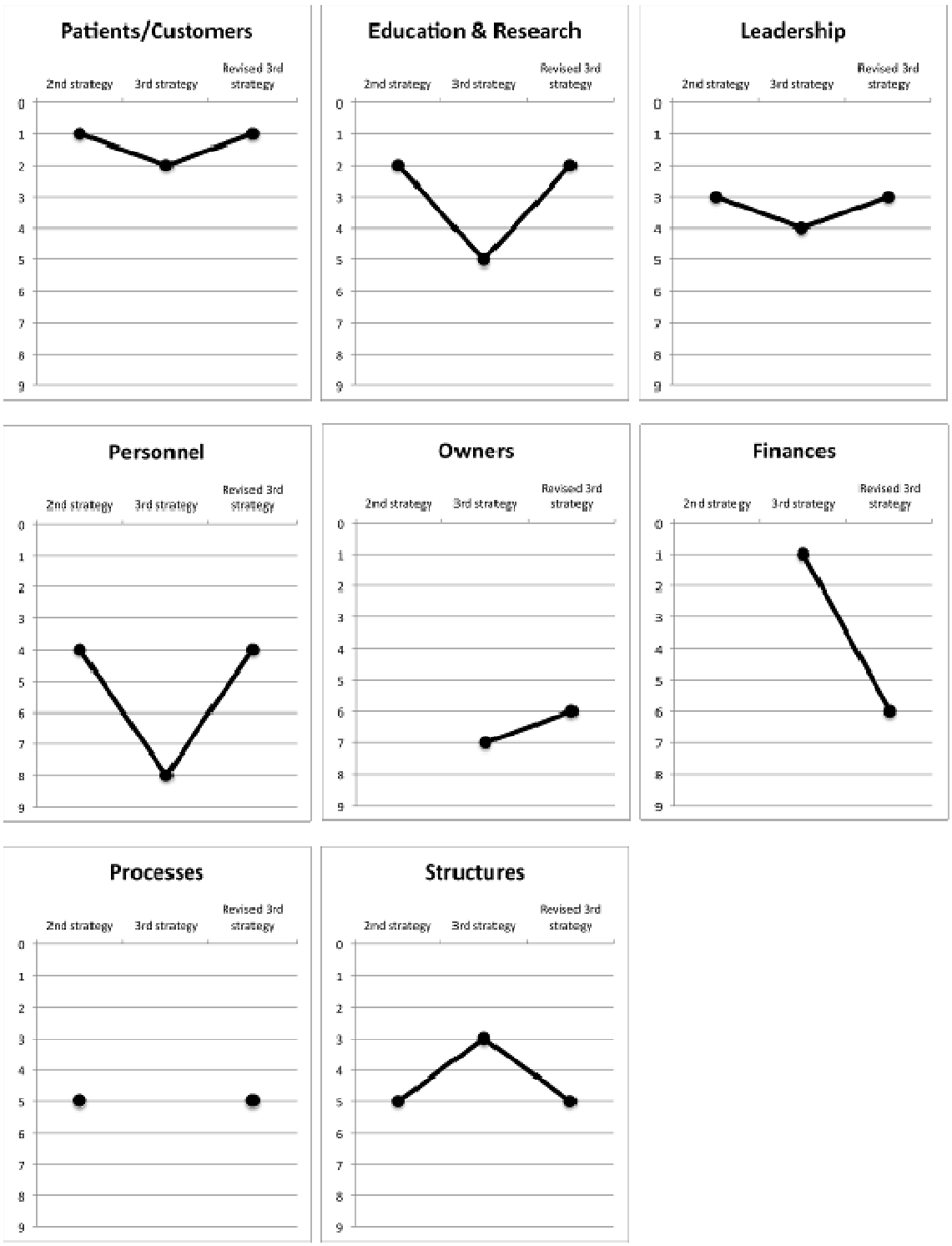
2nd strategy (2006 – 2015)		
Focus area	*Strategic objective in Finnish*	**Strategic objective in English**
1. Patients	*1. Pidämme potilaista huolta.*	1. We take care of patients.
2. Education and research	*2. Ylläpidämme ja kehitämme huippu-tutkimuksen verkostoja ja koulu-tamme tulevaisuuden ammattilaisia.*	2. We maintain and develop networks for top-class research and provide education for future professionals.
3. Leadership	*3. Vahvistamme asiantuntevaa ja ihmisläheistä johtamiskulttuuria.*	3. We strengthen competent and humane leadership culture.
4. Personnel	*4. Rekrytoimme, kehitämme, pidämme huolta ja palkitsemme henkilöstöä.*	4. We recruit, develop, take care of and reward personnel.
5. Processes and structures	*5. Teemme yhteistyötä optimaalisen palvelu-järjestelmän ja saumattomien palveluketjujen hyväksi.*	5. We cooperate to achieve an optimal service system and seamless service chains.

3rd strategy (2008 – 2015)		
Focus area	*Strategic objective in Finnish*	**Strategic objective in English**
1. Finances	*1. Talous on ennakoitavissa ja tasapainossa.*	1. Finances predictable and balanced.
2. Customers	*2. Asiakaslähtöinen ja vaikuttava erikoissairaanhoito.*	2. Customer oriented and influential specialised medical care.
3. Services and structures	*3. Uudistuvat palvelut ja rakenteet.*	3. Reforming services and structures.

4. Leadership	*4. Selkeä johtamisjärjestelmä ja huippujohtaminen.*	4. Clear management model and top class leadership.
5. Education and research	*5. Tutkimus-, opetus- ja kehittämistyö maailman huippua yhteistyössä yliopiston kanssa.*	5. World-class research, education and development in cooperation with university.
6. Finances and quality	*6. Palvelujen tuottavuuden, vaikuttavuuden ja laadun jatkuva parantaminen liiketaloudellisten periaatteiden mukaisesti.*	6. Continuous improvement of service productivity, effectiveness and quality according to business principles.
7. Owners	*7. Lisäarvoa tuottava ja läpinäkyvä omistajaohjaus.*	7. Value adding and transparent governance.
8. Personnel	*8. Alan vetovoimaisin työpaikka.*	8. Most attractive workplace in the sector.

Revised 3rd strategy (2009 – 2015)		
Focus area	*Strategic objective in Finnish*	**Strategic objective in English**
1. Patients	*1. Potilaslähtöinen, vaikuttava ja oikea-aikainen erikoissairaanhoito*	1. Patient-oriented, effective and timely organised specialised medical care
2. Education and research	*2. Korkeatasoinen tutkimus ja opetus yhteistyössä Helsingin yliopiston, muiden korkea-koulujen ja ammattioppilaitosten kanssa.*	2. High-level research and teaching in cooperation with the University of Helsinki and other universities and vocational institutes
3. Leadership	*3. Moniammatillista asiantuntijayhteisöä kannustava ja arvostava johtaminen.*	3. Leadership that supports and values the multi-professional community of experts
4. Personnel	*4. Alan vetovoimaisin monien mahdollisuuksien työpaikka.*	4. The sector’s most attractive workplace, abundant with opportunity
5. Processes and structures	*5. Toimintatapojen ja rakenteiden jatkuva parantaminen.*	5. Continuous improvement in structures and modes of operation
6. Owners and finances	*6. Luottamukseen perustuva kuntayhteistyö ja ennakoitavissa oleva tasapainoinen talous.*	6. Municipal cooperation founded on trust and predictable, well balanced finances

Appendix 2. The changes in the order of strategic objectives in a period of 2006 – 2009.



Appendix 3. Comparing the strategic objectives of university hospital districts in Finland.

Hospital District	Population (31.12.2008)	Strategy Period	Presentation of Strategic Objectives
HUS	1,495,000	2009 – 2015	• Strategic objectives in a numbered order
Southwest Finland	248,000	2007 – 2015	• Strategic objectives in a numbered order • Subareas of focus presented for each strategic objective • Metrics integrated to the strategy description
Northern Ostrobothnia	465,000	2002 – 2008	• Strategic objectives described in a framework of balanced scorecard • Definitions of required actions integrated to the strategy description
Northern Savo	477,000	2009 – 2013	• Strategic objectives in a numbered order • Strategic objectives described in a framework of balanced scorecard • Definitions of required actions integrated to the strategy description
Pirkanmaa	390,000	2007 – 2012	• Strategy description includes sets of ethical guidelines and operating principles with broad explanations for each principle

Focus Area	Hospital District	Strategic Objective
Patients	HUS	1. Patient-oriented, effective and timely organised specialized medical care
	Northern Savo	1. Influential well-timed care
	Southwest Finland	1. Patient centric services
	Pirkanmaa	*Various principles concerning patients*
	Northern Ostrobothnia	*Various actions concerning patients*
Education and Research	HUS	2. High-level research and teaching in cooperation with the University of Helsinki and other universities and vocational institutes
	Northern Savo	2. Respected research, educational and development activities
	Southwest Finland	4. Strong cooperation with university
	Pirkanmaa	*Various principles concerning education and research*
	Northern Ostrobothnia	*Various actions concerning education and research*

Leadership	HUS	3. Leadership that supports and values the multi-professional community of experts
	Northern Savo	7. Strategy endorsing management system
	Southwest Finland	8. Good leadership and coherent standards of operation
	Pirkanmaa	*Various principles concerning leadership*
	Northern Ostrobothnia	*Various actions concerning leadership*
Personnel	HUS	4. The sector's most attractive workplace, abundant with opportunity
	Northern Savo	4. Regenerating and skilled personnel 5. Magnetic work community
	Southwest Finland	6. Competence and well-being of personnel
	Pirkanmaa	*Various principles concerning personnel*
	Northern Ostrobothnia	*Various actions concerning personnel*
Processes and structures	HUS	5. Continuous improvement in structures and modes of operation
	Northern Savo	2. Well functioning service entities
	Southwest Finland	3. Appropriate model for care production 5. Clear organization 7. Well-developed infrastructure
	Pirkanmaa	*Various principles concerning processes and structures*
	Northern Ostrobothnia	*Various actions concerning processes and structures*
Owners and Finances	HUS	6. Municipal cooperation founded on trust and predictable, well balanced finances
	Northern Savo	6. Balance of finance
	Southwest Finland	2. Efficient operations
	Pirkanmaa	*Various principles concerning owners and finances*
	Northern Ostrobothnia	*Various actions concerning finances*

Appendix 4. Kaiser Permanente in brief.

Founded in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and not-for-profit health plans. Headquartered in Oakland California, it is currently serving 8.6 million members in nine states and the District of Columbia. Kaiser Permanente is an integrated managed care organization that comprises Kaiser Foundation Health Plan, Kaiser Foundation Hospitals and the Permanente Medical Groups. The key figures of Kaiser Permanente as of 31st of December 2008 are as follows:

- more than 8.6 million health plan members
- 14,641 physicians
- 40,451 nurses
- 167,338 employees
- 35 hospitals
- 431 medical office buildings
- $1.5 billion in operating income (2008)
- $40.3 billion in operating revenues (2008).

The mission of Kaiser Permanente is to provide high-quality, affordable health care services to improve the health of its members and the communities it serves. Care for members and patients is focused on their total health and guided by their personal physicians, specialists and team of caregivers. The expert and caring medical teams are empowered and supported by technological advances and tools for health promotion and disease prevention. Physicians are responsible for medical decisions and the care providers continuously develop and refine medical practices to help ensure that care is delivered in the most efficient and effective manner possible. Kaiser Permanente is reportedly dedicated to invest on innovations, clinical research, health education and the support of community health.

According to Kaiser Permanente, it has brought for instance the following innovations to the US health care:

- Prepaid health plans to spread the cost and make it more affordable for patients
- Physician group practice to maximize the abilities to care for patients
- Focus on preventing illness as much as on caring for the sick
- Organized delivery system, putting as many services as possible under one roof.

The strategic choices of Kaiser Permanente are further described in Appendix 5 of this report.

Appendix 5. Strategic choices of Kaiser Permanente compared to Finnish health care.

Kaiser Permanente System	**Potential Challenges in Finnish Health Care**
1. Integrated health care system.	1. Fragmented health care system (sector level challenge).
2. Tight cooperation between primary health care and specialized medical care (e.g. for minimizing the time patients spend in high-cost hospital beds).	2. Cooperation between primary health care and specialized medical care not strengthened in partnerships.
3. Focus on value for patient (health outcomes).	3. Focus on cost-effectiveness.
4. Focus on full cycle of care (including monitoring, prevention, treatment and disease management).	4. Focus on discrete interventions (e.g. in measuring).
5. Value creation in the medical condition level (e.g. diabetes).	5. Value creation in the medical circumstance level (e.g. circulation problems).
6. Multi-disciplinary integrated practice units with learning and innovation in teams.	6. Functional departments and fragmented operations not enhancing learning in medical condition level.
7. High degree of patient involvement in prevention, disease management and after-care.	7. Low degree of patient involvement in prevention, disease management and after-care.
8. Integrated electronic medical records.	8. Non-integrated medical records.
9. Specialization with scale advantages.	9. Broad service offering in all sites without scale advantages.
10. Patients seeking the best value providers.	10. Municipalities guiding patients to a single hospital district (sector level challenge).

Appendix 6. List of conducted semi-structured interviews.

Interviewee	**Stakeholder group**	**Interview Date (dd.mm.yyyy)**
Chief Executive Officer 2007 ->	Top executives	28.05.2009
Chief Medical Officer 2009 ->	Top executives	02.09.2009
Deputy Managing Director 2007 - 2008	Top executives	28.05.2009
Chief Development Officer 2008 ->	Top executives	11.06.2009
Chief Physician, opinion leader in HUCH area	Personnel	13.05.2009
Chair of HUS Executive Board 2005 - 2008	Owners (executive board)	27.05.2009
Chair of HUS Executive Board 2009 ->	Owners (executive board)	20.05.2009
Managing Director of the Health Centre, City of Helsinki	Customers/owners (municipalities)	29.05.2009
Director of Social Affairs and Health, City of Vantaa	Customers/owners (municipalities)	19.05.2009
Chancellor Emeritus	Partners (University of Helsinki)	25.05.2009
Professor, member of HUS Executive Board, former Chief Medical Officer at HUS	Partners (University of Helsinki)	11.05.2009
Trustee at HUS, Finnish Medical Association	Partners (labor unions)	28.05.2009
President, Tehy	Partners (labor unions)	18.05.2009
Secretary General, Finnish Heart Association	Customers (patient organizations)	08.06.2009
Secretary General, Cancer Society of Finland	Customers (patient organizations)	29.05.2009

Appendix 7. Predefined questions of semi-structured interviews.

	Question in Finnish	Question in English
Background		
1.	*Kuvailkaa muutamalla sanalla sidosryhmänne suhdetta HUS:n organisaatioon?*	Describe briefly the relations of your stakeholder group to HUS organization.
2.	*Miten hyvin tunnette HUS:n nykyisen ja sitä edeltävät strategiat? (Oma historianne HUS:n sidosryhmän edustajana?)*	How well are you familiar with the current and previous strategies of HUS? (Your own history as a stakeholder group representative?)
Strategy preparation phase		
3.	*Miten sidosryhmänne näkee strategian uudistamisen ja strategisen johtamisen tarpeellisuuden HUS:ssa?*	How does your stakeholder group see the need of strategy renewal and strategic management at HUS?
4.	*Miten sidosryhmänne vaikutusvalta on näkynyt HUS:n strategiaprosessissa (sen eri vaiheissa)? Entä muiden sidosryhmien vaikutusvalta?*	How has the influencing power of your stakeholder group appeared in the strategy process of HUS? What about the influencing powers of other stakeholders?
5.	*Miten mielipidejohtajat on huomioitu strategiaprosessissa (sen eri vaiheissa)?*	How have the opinion leaders been acknowledged during the strategy process?
6.	*Miten kuvailisitte HUS:n organisaation kykyä ja valmiutta muuttua strategisen johtamisen kautta? (Onko HUS:n organisaatiokulttuuri huomioitu muutosten valmistelussa?)*	How would you describe the capability and readiness of HUS organization to change through strategic management? (Is the organizational culture of HUS considered in the preparation of changes?)
Strategy planning phase		
7.	*Kannustettiinko sidosryhmäänne osallistumaan aktiivisesti kahden viimeisen strategian suunnitteluun tai kommentointiin? (Entä muita sidosryhmiä?)*	Was your stakeholder group encouraged to participate actively the planning and commenting of the most recent strategy? (What about the other stakeholders?)
8.	*Miten sidosryhmänne ja HUS:n johdon välinen strategiaan liittyvä vuoropuhelu tapahtuu käytännössä?*	How is the strategic dialogue between your stakeholder group and HUS management organized in practice?
9.	*Missä määrin eri sidosryhmien tulisi osallistua strategiatyöhön? (Vaikuttaako osallistumismahdollisuudet strategian eteenpäinvientiin?)*	To what extent should different stakeholders participate in strategy work? (Does the influencing possibilities affect the strategy execution?)
10.	*Onko nykyinen strategia ollut eri sidosryhmien yhteistyön tulos? Entä nykyistä edeltävä strategia? Oliko eroja?*	Is the current strategy a result of collaboration by different stakeholders? What about the previous strategy? Where there differences between these two?

11.	*Koetteko, että sidosryhmänne odotukset ovat olleet strategian suunnittelijoiden tiedossa kahta viimeistä strategiaa valmisteltaessa?*	Do you feel that the expectations of your stakeholder group were known by the strategy planners when preparing the last two strategies?
12.	*Miten nykyinen strategia vastaa sidosryhmänne odotuksia? Entä nykyistä edeltävä strategia?*	How does the current strategy meet your stakeholder group's expectations? What about the previous strategy?
13.	*Mitä vaikutuksia nykyisellä strategialla on sidosryhmäänne tai sen asemaan? Entä muihin sidosryhmiin?*	What kind of impacts does the current strategy have on your stakeholder group or its position? What about the other stakeholders?
14.	*Onko nykyinen strategia toteutettavissa käytettävissä olevin resurssein? Entä nykyistä edeltävä strategia? (Soveltuuko strategia toimintaympäristöön ja vastaako se tulevaisuuden haasteisiin?)*	Is the current strategy feasible with the currently available resources? What about the previous strategy? (Is the strategy suitable to current operating environment and future challenges?)
15.	*Strategiset päämäärät on numeroitu tiettyyn järjestykseen. Koetteko numeroinnin vaikuttaneen strategian hyväksyntään? (Pidättekö numerointia onnistuneena ja/tai tarpeellisena?)*	The strategic objectives are numbered in a specific order. Do you suspect the numbering to have had any impacts on the strategy acceptance? (Do you find the numbering successful and/or necessary?)
Strategy execution phase		
16.	*Koetteko, että strategiset tavoitteet ohjaavat käytännön toimintaa? Onko tukena operatiivisia strategioita tai toimenpidesuunnitelmia?*	Do you think that the strategic goals steer the operations in practice? Are there any supporting operational level strategies or action plans?
17.	*Miten kuvailisitte (lyhyesti) organisaation kykyä ja osaamista suunnitella ja jalkauttaa operatiivisen tason strategioita?*	How would you describe (briefly) the capability and competence of the organization to plan and execute operational level strategies?
18.	*Miten suunnitellut organisaatiomuutokset vaikuttivat nykyistä edeltävän strategian saamaan vastaanottoon?*	How did the planned organizational changes affect the reactions to the previous strategy?
19.	*Miten kahden viimeisen strategian kommunikointi HUS:n henkilöstölle on onnistunut (oliko konkretiaa)? Entä kommunikointi eri sidosryhmille? (Onko viestintä ollut organisaation arvot huomioivaa?)*	How did the communication of the last two strategies to personnel succeed (were there concreteness)? What about communication to different stakeholders? (Did the communication take the organizational values into account?)
20.	*Miten nykyisen strategian käytäntöön vieminen on lähtenyt liikkeelle?*	How has the execution of current HUS strategy started off?
21.	*Mitkä tekijät ovat edesauttaneet/estäneet HUS:n eri strategioiden onnistumista? Menestystekijät jatkossa?*	What have been the factors promoting/preventing the success of different strategies? Success factors for the future?

Appendix 8. List of superior job titles for telephone survey.

The following job titles were included in the survey population:

- vastaava X (responsible X)
- johtava X (leading X)
- yli X (chief X)
- X päällikkö (X manager)
- X johtaja (X director)
- X vastuulääkäri (X responsible physician)
- X esimies (X supervisor)
- osastonhoitaja (head nurse of a department)
- osastonylilääkäri (chief physician of a department)
- apulais X (deputy X, e.g. deputy chief physician)

However in principle the following job titles were excluded from the survey population:

- projektipäällikkö (project manager)
- asiakkuuspäällikkö (account manager)
- apulaisosastonhoitaja (deputy head nurse of a department).

Appendix 9. Description of interviewed employees in a summary level.

Hospital area or business enterprise category	Staff category	Profit unit or business enterprise	Number of interviewees
small business enterprises (< 501 employees per enterprise)	other staff	HUS Pharmacy	1
		HUS Medical Engineering	2
		HUS ICT Engineering	3
		Ravioli	1
large business enterprises (> 500 employees per enterprise)	other staff	HUS-Desiko	3
	nursing staff	HUS-Röntgen	2
	physicians	HUS-Röntgen	3
	nursing staff	HUSLAB	4
	physicians	HUSLAB	6
	other staff	HUSLAB	1
Hyvinkää	nursing staff	Medicinal profit unit	1
		Profit unit of gynecology and pediatric care	2
		Psychiatric profit unit	3
	physicians	Medicinal profit unit	1
		Profit unit of gynecology and pediatric care	2
		Operative profit unit	1
Länsi-Uusimaa	nursing staff	Psychiatric profit unit	2
	physicians	Profit unit of gynecology and pediatric care	1
		Operative profit unit	1
Lohja	nursing staff	Medicinal profit unit	1
		Operative profit unit	1
	physicians	Operative profit unit	2
		Psychiatric profit unit	1
HUCH	nursing staff	Medicinal profit unit	10
		Profit unit of gynecology and pediatric care	6
		Operative profit unit	9
		Psychiatric profit unit	4
	physicians	Medicinal profit unit	8
		Profit unit of gynecology and pediatric care	4
		Operative profit unit	11
		Psychiatric profit unit	2
	other staff	Operative profit unit	1
		Psychiatric profit unit	1
Porvoo	nursing staff	Administration of hospital area	2
	physicians	Profit unit of gynecology and pediatric care	1
		Psychiatric profit unit	1
Total			105

Key figures of the respondents:

- Sample size: 105 respondents (6% of the target population)
- Sex: 70% women and 30% men
- Age: 32 - 65 years (average of 52 years)
- Average duration of the current term of employment: 19 years.

Appendix 10. Statements and answer alternatives presented in the telephone survey.

	Statement in Finnish	Statement in English
Background (theme not mentioned to the interviewee)		
Q1	*Olen tietoinen, että HUS:n strategiset päämäärät tarkistettiin viime vuoden lopulla.*	I am aware that the strategic objectives of HUS were revised in the end of last year.
Q2	*Tunnen hyvin HUS:n nykyiset strategiset päämäärät.*	I am familiar with the current strategic objectives of HUS.
Acceptability of strategy (theme not mentioned to the interviewee)		
Q3	*Mielestäni HUS:n strategia on parempi sen tarkistamisen jälkeen.*	In my opinion, the strategy of HUS is better after its revision.
Q4	*Alaiseni suhtautuvat myönteisemmin HUS:n strategiaan sen tarkistamisen jälkeen.*	My subordinates have a more positive stand towards strategy after its revision.
Q5	*Esimieheni suhtautuu myönteisemmin HUS:n strategiaan sen tarkistamisen jälkeen.*	My superior has a more positive stand towards strategy after its revision.
Q6	*HUS:n nykyinen strategia vastaa yksikköni henkilöstön odotuksia.*	The current strategy of HUS meets the expectations of personnel in my department.
Q7	*HUS:n nykyinen strategia soveltuu toimintaympäristöön.*	The current strategy of HUS is suitable in the current environment of operation.
Readiness to change (theme not mentioned to the interviewee)		
Q8	*On tärkeää, että HUS:lla on strategia.*	It is important that HUS has a strategy.
Q9	*Uskon, että HUS:n toimintaa voi ohjata strategian kautta.*	I believe that HUS operations can be steered through strategy.
Q10	*Strategian tarve on hyvin perusteltu ja tiedossa yksikössäni.*	The necessity of strategy is well justified and made known in my department.
Q11	*Suhtaudun myönteisesti strategiseen kehittämiseen.*	I have a positive stand towards strategic development.
Q12	*Yksikössäni suhtaudutaan myönteisesti muutoksiin.*	In my department there is a positive stand towards changes.
Possibilities to influence the strategy process (theme not mentioned to the interviewee)		
Q13	*Minusta henkilöstö on saanut sanoa mielipiteensä HUS:n strategiaa valmisteltaessa.*	In my opinion, personnel could say their opinion in the preparation of HUS strategy.
Q14	*Henkilöstön edustajien mielipiteet ovat vaikuttaneet HUS:n strategian sisältöön.*	The opinions of personnel's representatives have affected the contents of the HUS strategy.
Q15	*Mielipidejohtajat edustavat hyvin henkilöstön todellisia mielipiteitä.*	Opinion leaders represent well the true opinions of personnel.

Q16	*Strategian valmistelussa henkilöstön sopivia edustajia ovat henkilöstöjärjestöjen nimeämät henkilöt.*	The persons nominated by unions of personnel are suitable representatives of personnel in preparation of strategy.
Q17	*Strategian toteutuminen onnistuu, jos esimieskuntaa on mukana strategian suunnittelussa.*	Strategy execution is successful if personnel in superior positions participate in planning of strategy.
Q18	*Henkilöstön pitää mielestäni osallistua vahvasti strategian valmisteluun.*	In my opinion, personnel should participate strongly in preparation of strategy.
Q19	*HUS:n nykyinen strategia on ollut johdon ja henkilöstön yhteistyön tulos.*	The current strategy of HUS is a result of a collaborative effort by management and personnel.
Goal clarity (theme not mentioned to the interviewee)		
Q20	*HUS:n strategiaan kirjatut strategiset päämäärät ovat selkeitä.*	The strategic objectives written in the HUS strategy are clear.
Q21	*HUS:n strategisten päämäärien numeroinnilla on vaikutusta mielipiteeseeni strategiasta.*	The numbering of strategic objectives affects my opinion of HUS strategy.
Q22	*Minulla on selkeä käsitys siitä, mitä HUS:n strategia tarkoittaa oman ja alaisteni työn kannalta.*	It is clear for me what HUS strategy means for my own and my subordinates' work.
Q23	*Yksikössäni päivittäisen työmme tavoitteet perustuvat HUS:n strategiaan.*	Goals in our daily work are based on the HUS strategy.
Q24	*Yksikössäni on luotu toimenpidesuunnitelmia HUS:n strategian pohjalta.*	In my department action plans have been created based on the HUS strategy.
Effects of the change to own duties or position (theme not mentioned to the interviewee)		
Q25	*Uskon, että HUS:n strategialla on suora vaikutus omaan työskentelyyni tai asemaani organisaatiossa.*	I believe that HUS strategy has a direct impact to my own work duties or position in the organization.
Q26	*Suunniteltu organisaatiomuutos vaikutti HUS:n strategian hyväksyttävyyteen viime vuonna.*	The planned organizational change affected the acceptability of HUS strategy last year.
Complexity of the change (theme not mentioned to the interviewee)		
Q27	*HUS:n nykyinen strategia on toteutettavissa käytettävissä olevin resurssein.*	The current strategy of HUS is feasible with the currently available resources.
Q28	*Yksikössäni on valmiudet suunnitella ja toteuttaa operatiivisen tason strategioita.*	In my department there exists a readiness to plan and execute operational level strategies.
Q29	*Koen itseni ensisijaisesti HUS:laiseksi, enemmän kuin oman yksikköni edustajaksi.*	I see myself primarily as a HUS employee rather than a representative of my department.

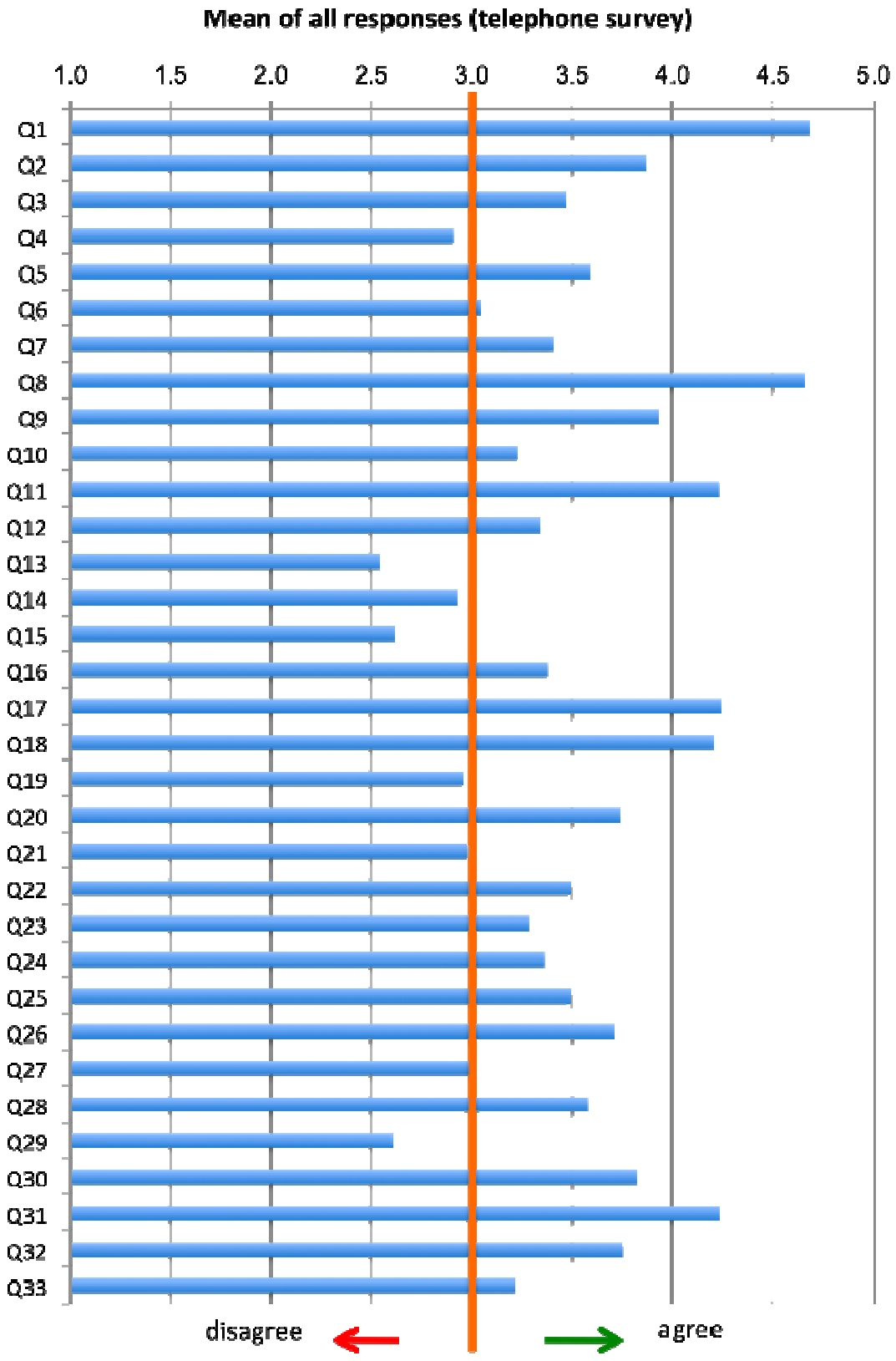
Management capability (theme not mentioned to the interviewee)		
Q30	*Olen saanut hyvin tietoa HUS:n strategian sisällöstä.*	I have received well of information on the contents of the HUS strategy.
Q31	*Minulla on esimiehenä tärkeä rooli siinä, miten alaiseni suhtautuvat HUS:n strategiaan.*	As a superior, my role is important when considering my subordinates' standpoints towards HUS strategy.
Q32	*Yksikköni esimieskunta on sitoutunut HUS:n strategian toteuttamiseen.*	In my department the employees in superior positions are committed to execution of HUS strategy.
Q33	*HUS:n nykyisen strategian toteuttaminen on lähtenyt yksikössäni hyvin liikkeelle.*	The execution of current HUS strategy has started off well in my department.
Personal details		
Q34	*Syntymävuotenne?*	Year of your birth?
Q35	*Aloitusvuotenne HUS:ssa (tai HUS:iin nykyisin kuuluvan työnantajan palveluksessa)?*	Year of you starting at HUS (or at an employer part of HUS today)?
Q36	*Sairaanhoitoalue, jossa työskentelette?*	Hospital area, where you work?
Q37	*Sairaala tai toimipiste, jossa työskentelette?*	Hospital or site, where you work?
Q38	*Tulosyksikkö tai liikelaitos, jossa työskentelette?*	Profit unit or business enterprise, where you work?
Q39	*Tehtävänimikkeenne?*	Your job title?

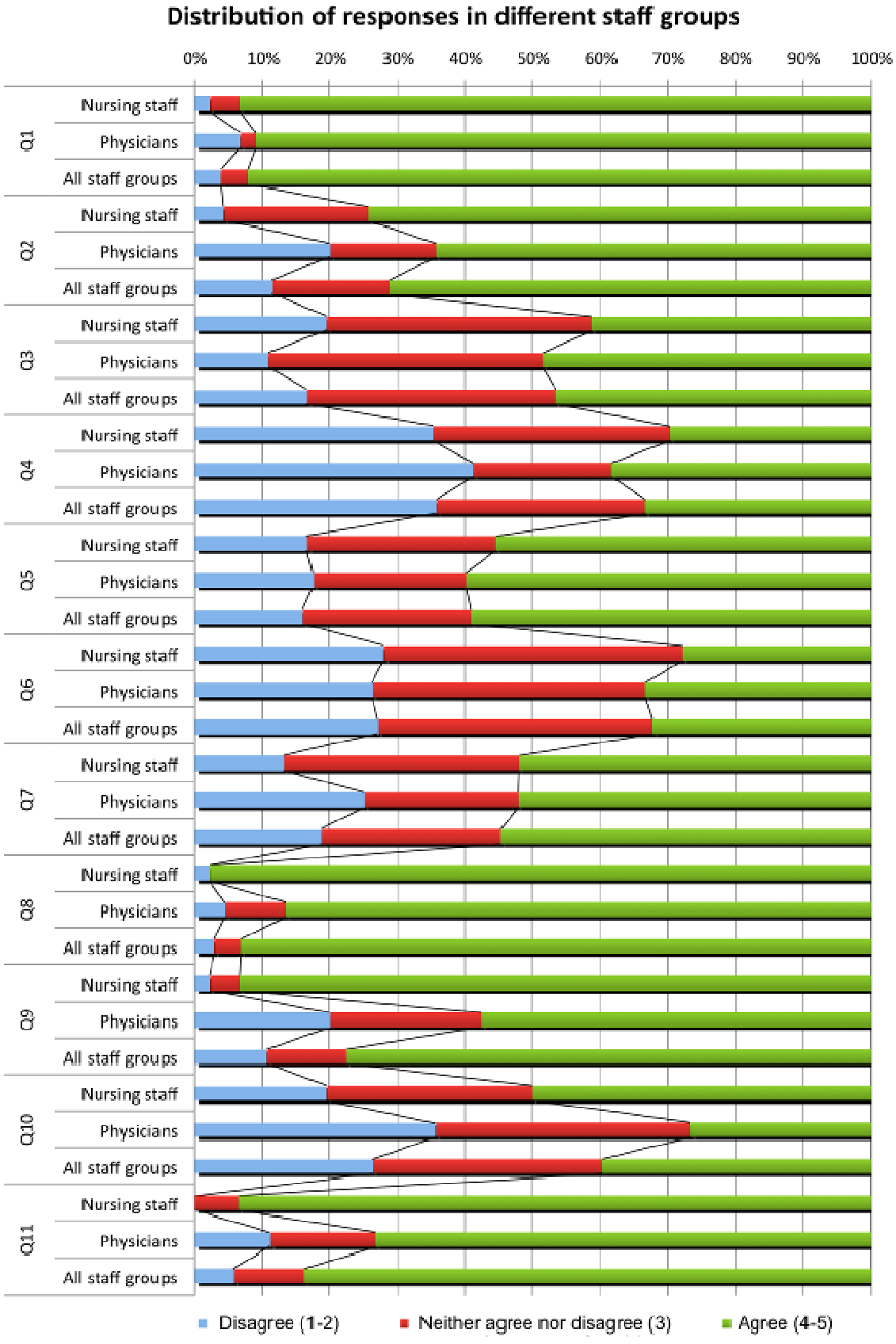
Answer alternatives in Finnish	Answer alternatives in English
5: Täysin samaa mieltä	5: Agree completely
4: Osin samaa mieltä	4: Agree partly
3: Ei samaa eikä eri mieltä	3: Neither agree nor disagree
2: Osin eri mieltä	2: Disagree partly
1: Täysin eri mieltä	2: Disagree completely
e: en osaa sanoa.	e: Can't say

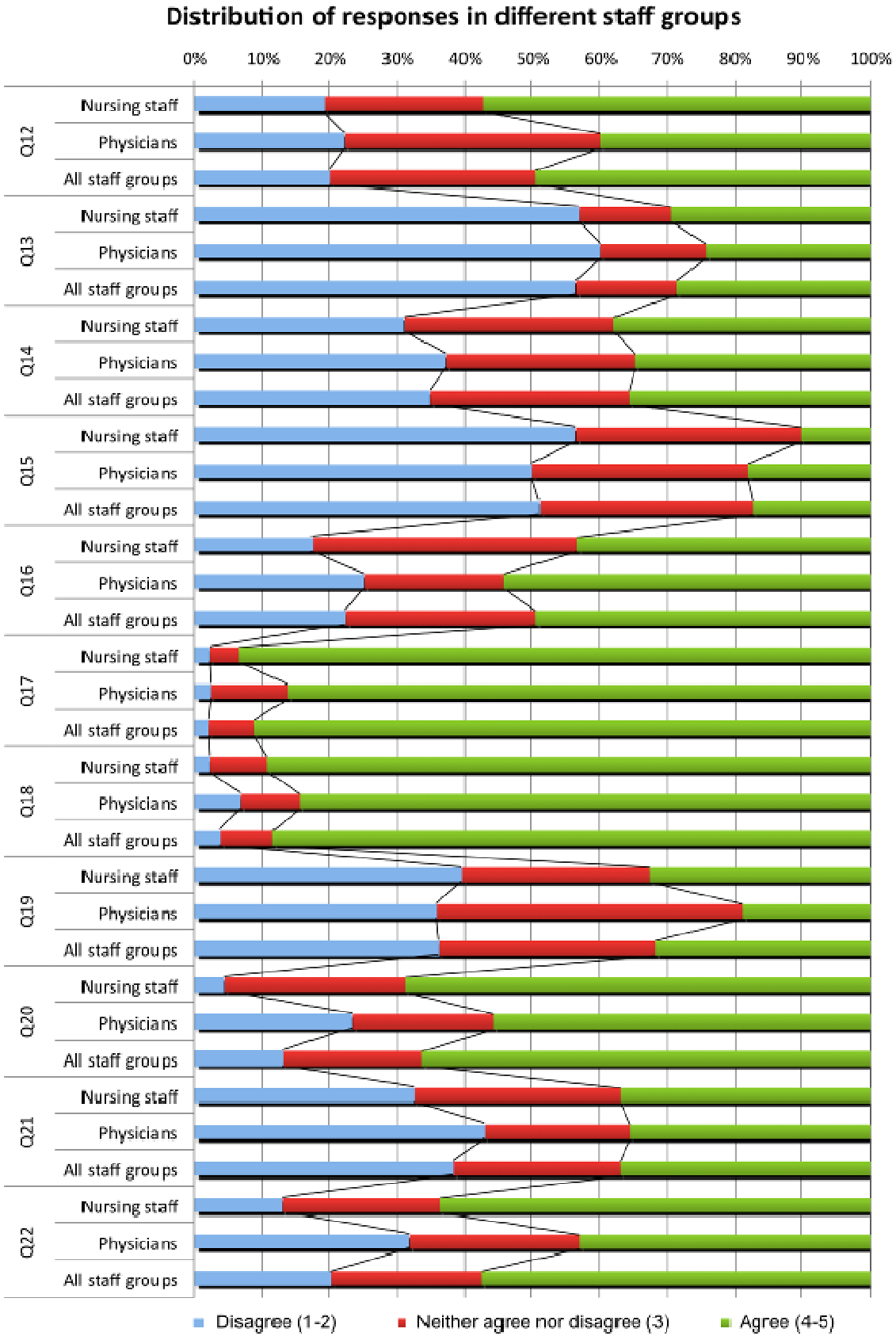
Appendix 11. Results of telephone survey for HUS personnel.

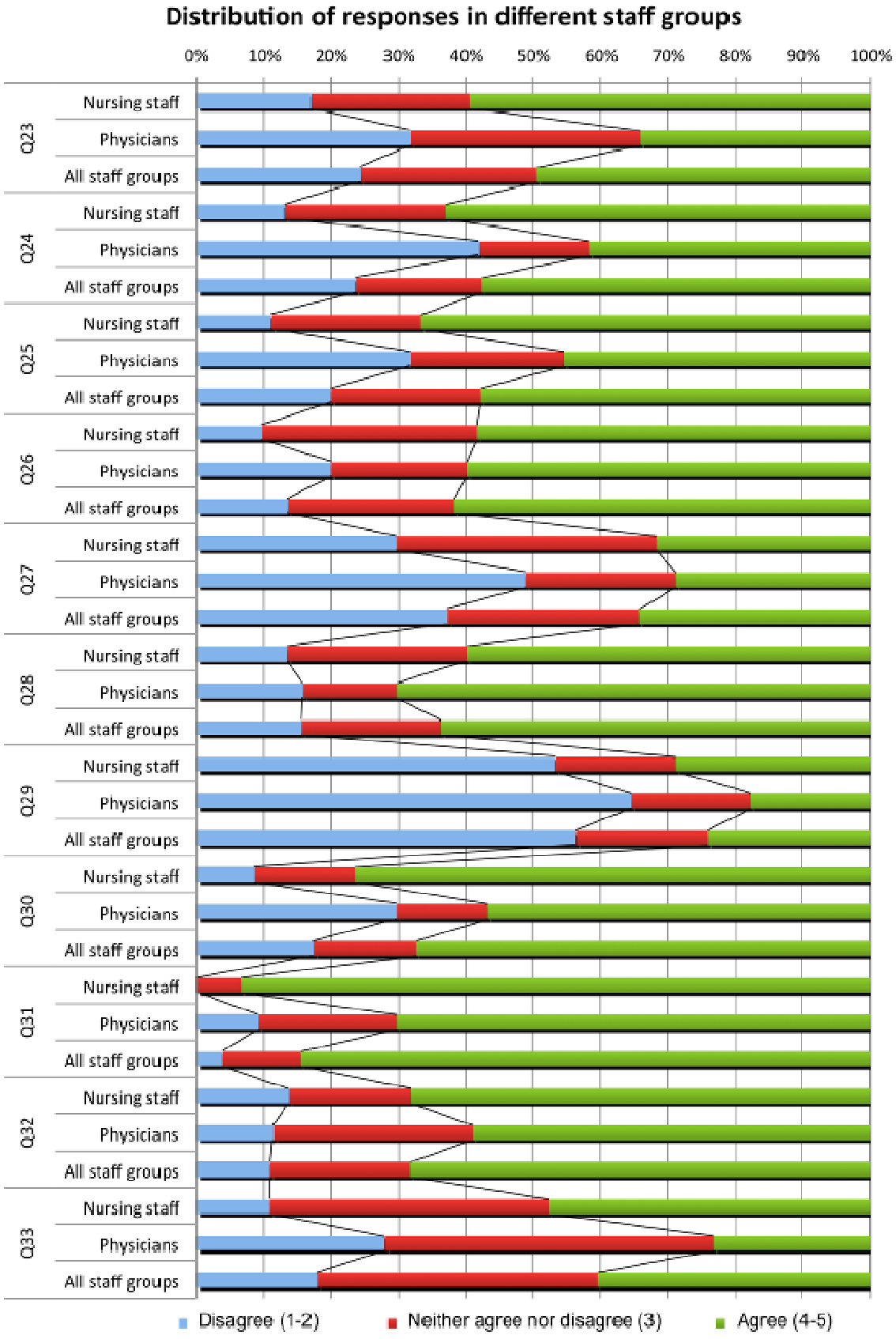
Means and distributions of responses					
#	**Statement**	**Mean**	**Disagree (1-2)**	**Neither agree nor disagree (3)**	**Agree (4-5)**
Q1	I am aware that the strategic objectives of HUS were revised in the end of last year.	4,68	4%	4%	92%
Q2	I am familiar with the current strategic objectives of HUS.	3,87	11%	17%	71%
Q3	In my opinion, the strategy of HUS is better after its revision.	3,47	17%	37%	47%
Q4	My subordinates have a more positive stand towards strategy after its revision.	2,90	36%	31%	33%
Q5	My superior has a more positive stand towards strategy after its revision.	3,59	16%	25%	59%
Q6	The current strategy of HUS meets the expectations of personnel in my department.	3,04	27%	41%	32%
Q7	The current strategy of HUS is suitable in the current environment of operation.	3,40	19%	26%	55%
Q8	It is important that HUS has a strategy.	4,66	3%	4%	93%
Q9	I believe that HUS operations can be steered through strategy.	3,93	11%	12%	78%
Q10	The necessity of strategy is well justified and made known in my department.	3,22	26%	34%	40%
Q11	I have a positive stand towards strategic development.	4,23	6%	10%	84%
Q12	In my department there is a positive stand towards changes.	3,34	20%	30%	50%
Q13	In my opinion, personnel could say their opinion in the preparation of HUS strategy.	2,54	56%	15%	29%
Q14	The opinions of personnel's representatives have affected the contents of the HUS strategy.	2,93	35%	29%	36%
Q15	Opinion leaders represent well the true opinions of personnel.	2,61	51%	32%	17%
Q16	The persons nominated by unions of personnel are suitable representatives of personnel in preparation of strategy.	3,38	22%	28%	50%

Q17	Strategy execution is successful if personnel in superior positions participate in planning of strategy.	4,24	2%	7%	91%
Q18	In my opinion, personnel should participate strongly in preparation of strategy.	4,20	4%	8%	89%
Q19	The current strategy of HUS is a result of a collaborative effort by management and personnel.	2,96	36%	32%	32%
Q20	The strategic objectives written in the HUS strategy are clear.	3,74	13%	21%	66%
Q21	The numbering of strategic objectives affects my opinion of HUS strategy.	2,98	38%	24%	37%
Q22	It is clear for me what HUS strategy means for my own and my subordinates' work.	3,49	20%	22%	58%
Q23	Goals in our daily work are based on the HUS strategy.	3,28	24%	26%	50%
Q24	In my department action plans have been created based on the HUS strategy.	3,36	24%	19%	58%
Q25	I believe that HUS strategy has a direct impact to my own work duties or position in the organization.	3,49	20%	22%	58%
Q26	The planned organizational change affected the acceptability of HUS strategy last year.	3,71	13%	25%	62%
Q27	The current strategy of HUS is feasible with the currently available resources.	3,00	37%	28%	34%
Q28	In my department there exists a readiness to plan and execute operational level strategies.	3,58	16%	21%	64%
Q29	I see myself primarily as a HUS employee rather than a representative of my department.	2,60	56%	19%	24%
Q30	I have received well of information on the contents of the HUS strategy.	3,82	17%	15%	67%
Q31	As a superior, my role is important when considering my subordinates' standpoints towards HUS strategy.	4,23	4%	12%	84%
Q32	In my department the employees in superior positions are committed to execution of HUS strategy.	3,75	11%	21%	68%
Q33	The execution of current HUS strategy has started off well in my department.	3,21	18%	42%	41%


Mean of all responses (telephone survey)
1.0
1.5
2.0
2.5
3.0
3.5
4.0
4.5
5.0
Q1
Q2
Q3
Q4
Q5
Q6
Q7
Q8
Q9
Q10
Q11
Q12
Q13
Q14
Q15
Q16
Q17
Q18
Q19
Q20
Q21
Q22
Q23
Q24
Q25
Q26
Q27
Q28
Q29
Q30
Q31
Q32
Q33
disagree
agree


Distribution of responses in different staff groups
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Q1
Nursing staff
Physicians
All staff groups
Q2
Nursing staff
Physicians
All staff groups
Q3
Nursing staff
Physicians
All staff groups
Q4
Nursing staff
Physicians
All staff groups
Q5
Nursing staff
Physicians
All staff groups
Q6
Nursing staff
Physicians
All staff groups
Q7
Nursing staff
Physicians
All staff groups
Q8
Nursing staff
Physicians
All staff groups
Q9
Nursing staff
Physicians
All staff groups
Q10
Nursing staff
Physicians
All staff groups
Q11
Nursing staff
Physicians
All staff groups
Disagree (1-2)
Neither agree nor disagree (3)
Agree (4-5)


Distribution of responses in different staff groups
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Q12
Nursing staff
Physicians
All staff groups
Q13
Nursing staff
Physicians
All staff groups
Q14
Nursing staff
Physicians
All staff groups
Q15
Nursing staff
Physicians
All staff groups
Q16
Nursing staff
Physicians
All staff groups
Q17
Nursing staff
Physicians
All staff groups
Q18
Nursing staff
Physicians
All staff groups
Q19
Nursing staff
Physicians
All staff groups
Q20
Nursing staff
Physicians
All staff groups
Q21
Nursing staff
Physicians
All staff groups
Q22
Nursing staff
Physicians
All staff groups
Disagree (1-2)
Neither agree nor disagree (3)
Agree (4-5)


Distribution of responses in different staff groups
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Q23
Nursing staff
Physicians
All staff groups
Q24
Nursing staff
Physicians
All staff groups
Q25
Nursing staff
Physicians
All staff groups
Q26
Nursing staff
Physicians
All staff groups
Q27
Nursing staff
Physicians
All staff groups
Q28
Nursing staff
Physicians
All staff groups
Q29
Nursing staff
Physicians
All staff groups
Q30
Nursing staff
Physicians
All staff groups
Q31
Nursing staff
Physicians
All staff groups
Q32
Nursing staff
Physicians
All staff groups
Q33
Nursing staff
Physicians
All staff groups
Disagree (1-2)
Neither agree nor disagree (3)
Agree (4-5)

Frequency of missing values (i.e. “can’t say” responses)

Statement	# of missing values (can't say)	Missing out of 105 respondents
Q1	1	1%
Q2	0	0%
Q3	15	14%
Q4	21	20%
Q5	24	23%
Q6	9	9%
Q7	3	3%
Q8	0	0%
Q9	2	2%
Q10	2	2%
Q11	0	0%
Q12	0	0%
Q13	4	4%
Q14	10	10%
Q15	13	12%
Q16	2	2%
Q17	1	1%
Q18	0	0%
Q19	8	8%
Q20	4	4%
Q21	11	10%
Q22	1	1%
Q23	2	2%
Q24	3	3%
Q25	5	5%
Q26	16	15%
Q27	3	3%
Q28	3	3%
Q29	2	2%
Q30	1	1%
Q31	2	2%
Q32	4	4%
Q33	4	4%

See Appendix 10 for explanations of the statement indicators (Q1–Q33).

Appendix 12. Milestones of the business project.

Milestone	Deliverables	Completion
1	First tutorial session (meeting).	March 2009
2	Identification of interviewees and permissions (e-mail, telephone).	April 2009
3	Selection of theoretical framework (meeting, doc).	April 2009
4	Business project (BP) plan submitted (doc).	April 2009
5	Second tutorial session (meeting).	April 2009
6	Questions for interviews ready (doc).	April 2009
7	Semi-structured interviews completed (meetings) + transcriptions ready (doc).	June 2009 *
8	BP interim report + headings of final BP report ready (ppt).	June 2009
9	Third tutorial session (meeting).	June 2009
10	Questions for telephone survey and sample plan ready (www).	July 2009
11	Data from semi-structured interviews analyzed (doc).	August 2009
12	Telephone survey completed (telephone).	August 2009
13	Data from telephone survey analyzed (spss/xls).	September 2009
14	Inferences made based on the data analyses (doc).	September 2009
15	Body of the project report written (doc).	September 2009
16	Final tutorial session (meeting).	September 2009
17	Project report edited and proofread (doc).	September 2009
18	Business project submitted (doc).	September 2009

* One of the semi-structured interviews was conducted in early September 2009.

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