Working Environment Activities in Hospitals: Expansion of Scope and Decentralization of Responsibility[1]

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ABSTRACT

This article analyzes how two development traits in the regulatory requirements for Working Environment (WE) activities – an expansion of scope and a decentralization of responsibility – are understood and handled over time by actors responsible for WE activities in Norwegian hospitals. The expanded scope of WE activities is studied based on the requirements outlined in The Working Environment Act, public health science theory, and the WE challenges in hospitals. The decentralized responsibility for WE activities is studied based on Internal Control (IC) reform and other hospital reforms inspired by New Public Management (NPM). The final section of the article discusses the effects of the two development traits, and how these enlarge the line manager's area of responsibility. The article is based on a qualitative, longitudinal study conducted in three Norwegian hospitals in 1998-1999 and 2013.

KEYWORDS

Health, environment, and safety / hospitals / internal control / line manager / longitudinal qualitative study / public health / working environment

Introduction

Since the 1970s, Working Environment (WE) has been the central concept used in Scandinavia to describe what was previously termed *Occupational Health and Safety* (OHS). The shift in language represents a movement away from focusing narrowly on health and safety hazards towards looking more broadly at factors that influence the quality of working life (Knudsen et al. 2011, p. 379). The purpose of The Norwegian Working Environment Act of 2005 (LOV-2005-06-17-62, § 1) reflects this more comprehensive approach to the concept of WE. The stated goal of the WE Act is to ensure complete safety for employees by preventing negative physical and mental effects, which provides the basis for promoting a healthy and meaningful work situation and for fostering inclusive working conditions.

The regulation of the Norwegian labor market can be considered parts of the common Nordic model, which is characterized by an institutional framework for negotiations, by the politics of distribution, and by conflict resolution. Within this framework,

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a Nordic model for regulating the WE has also been developed (Dyreborg 2011; Karlsen et al. 2018; Lindøe et al. 2001).

Lindøe et al. (2001, pp. 45–55) divide such a development into four phases. We have applied these four phases to a Norwegian context.

In the first phase, authorities became concerned with the prevention of accidents and ill health through exposure to physical and chemical WE agents. This was achieved through *legal regulation and control* (Lindøe et al. 2001). Norway received its first Working Environment law (the Factory Inspection Act) in 1892. The number of businesses covered by the law was later expanded in both 1909 and 1915 (NOU 1992: 20).

In the second phase, especially after the Second World War, the growth of social democratic governments and strong trade unions led to calls for *co-involvement* in WE laws and regulations. In 1956, a new Workers' Protection Act in Norway required representatives for the employees to participate in organized protection work (Lindøe et al. 2001; NOU 1992: 20).

In the third phase, novel technology and production processes demanded new forms of knowledge about working life (Lindøe et al. 2001). Increased awareness of *psychosocial and organizational WE factors* proliferated in the Nordic countries. The Norwegian Parliament passed a new Working Environment Act in 1977, inspired by the work of Thorsrud and Emery (1970).

The fourth phase modernized the regulatory system by progressing to reflexive WE legislation, in which authorities no longer regulated behavior through centralized measures and previously determined standards, but rather by adopting *decentralized management mechanisms*. These decentralized mechanisms were based on legislation and regulations that established framework conditions without providing much detail (Lindøe et al. 2001, p. 45). Norway introduced Internal Control (IC) as a tool for WE work in 1991. These regulations represented a new perspective on the state's role. Introducing IC in WE work in Norway and Sweden can be seen as a form of market adaptation (Lindøe et al. 2001).

This article focuses mainly on phases three and four. The development of knowledge about psychosocial and organizational WE factors in phase three *expanded the scope of the regulatory requirements of WE activities*. Increased emphasis on reflexivity in phase four led to a *decentralization of responsibility in WE activities*, and IC was introduced as an important tool in WE work. These are traits constituting politically desired development in the Norwegian context.

The purpose of this article is to analyze how two development traits in the regulatory requirements to WE activities are understood and handled over time by actors responsible for WE activities. We have limited our empirical study to three Norwegian somatic hospitals (Borgen 2014; Borgen & Lunde 2007, 2009). The research questions are:

1. How do actors with responsibility for WE activities in Norwegian hospitals understand and handle the expanded scope of WE requirements?
2. How do actors with responsibility for WE activities in Norwegian hospitals understand and handle the decentralization of responsibility that follows from changes in legislation? To what extent do these changes lead to local WE activities in hospital wards?

For the first research question, we explicate the expansion in scope of the regulatory requirements by considering WE activities as public health work within the arena of

working life. We have applied three different types of public health work (which are all used as terms in the WE Act of 2005): prevention, health promotion, and fostering of inclusive working conditions.

For the second research question, we examine how the decentralization of responsibility as a result of IC reform and other regulatory changes is understood and handled by relevant actors in WE activities.

The study can be described as a *longitudinal study*, consisting of two parts carried out over a 15-year period. This approach allowed us to study stability and change. For example, during this interval, there have been several changes in both the legislation and organization of hospitals. The methods involved are qualitative interviews and document analysis.

There have been increased calls by numerous scholars for more knowledge about how organizations implement and translate ideas, practices, and strategies to improve the WE. In a review of the management of OHS, Zanko and Dawson (2012 qtd. in Madsen & Hasle 2017, p. 19) found a lack of research on organizational implementation and, in particular, on how organizational actors interpret external institutional demands for OHS.

This article illustrates how external requirements in WE work are understood and handled by actors who are responsible for the implementation of WE activities in Norwegian hospitals.

Background

Expansion of the scope in the WE requirements

The scope of Norwegian WE requirements has been expanded, as new tasks have been added without former tasks being removed. Until 1977, The Working Environment Act emphasized prevention. The WE Act of 1977 included a new paragraph 12, in which the importance of health promotion was underscored (LOV-1977-02-04-4). The 2005 WE Act explicitly mentioned inclusive working conditions for the first time (LOV-2005-06-17-62). Thus, the new WE Act of 2005 uses three different public health science approaches. These are hereafter referred to as the three types of public health work: prevention, health promotion, and fostering of inclusive working conditions. These three types of public health work are complementary, but they can also compete for attention and resources.

Prevention refers to measures aimed at reducing diseases, injuries, social problems, fatality, and risk factors [St. meld. nr. 37 (1992–1993)]. In Norway, WE activities have traditionally been called *protection work* (‘*vernearbeid*’); Workers are to be protected against disease, exposure to dangerous substances, and other possible harm. There seems to be clear similarities between prevention and traditional protection work.

An important part of WE activities is to identify hazards and problems, to assess risk, and to develop plans and measures to reduce risk conditions (FOR-1996-12-06-1127, § 5). Preventive WE activities are usually associated with measures directed at physical-chemical risk factors and accidents, but they are also supposed to provide complete safety against harmful mental effects (LOV-2005-06-17-62, § 1).

Health promotion is the process of enabling people to increase control over and improve their own health (WHO 1986). Health is promoted through a population when

they participate as equal partners in social processes, and thus they have a greater influence over their own lives. The process is, in itself, meant to be health-promoting. While preventive work is largely based on medical models (Green et al. 2015, p. 21), health promotion is also based on contributions from disciplines such as psychology, pedagogy, economics, sociology, and communication theory (Bunton & Macdonald 1992).

In The WE Act of 2005 the concept of *health promoting* (*'helsefremmende'*) is used for the first time. This line of thought can, however, be retraced to the earlier WE Act of 1977, which emphasized both protection and participation (Karlsen & Lindøe 2006). The former paragraph 12 is often associated with Thorsrud and Emery (1970, p. 19) and their psychological work demands, which suggests that by participating in decisions and exercising greater control over the work process, employees achieve a more meaningful work situation. The workplace is a social system, in which learning, motivation, and personal development occupy central positions (Lindøe 2003). Health promotion activities are often not only associated with the psychosocial and organizational fields, but can also be connected to physical conditions.

The 2005 WE Act explicitly names *fostering of inclusive working conditions*, a measure intended to reduce work absence due to illness and early retirement. The goal of this type of public health work is to exclude the fewest number of employees possible, and to ensure that any potential barriers to entering the workforce are minimized. Inclusive working conditions are associated with *The Letter of Intent regarding a more inclusive working life* (IA Agreement), which is an agreement between parties in the workplace and the government (Norwegian Ministry of Labor and Social Affairs 2010). The workplace is the main arena for these IA-activities, and the main actors are the employer and the employees.

Decentralization of responsibility through Internal Control reform

WE activities form part of the entire systematic health, environment, and safety (HES) activities. When we carried out the two field works (1998-1999 and 2013), the objectives of the IC Regulations for HES activities were to promote workplace improvement in the following fields: (1) WE and safety, (2) prevention of health damage or environmental disturbances from products or consumer services, and (3) protection of the external environment against pollution and improvement in the treatment of waste (FOR-1996-12-06-1127, § 1). In this article we have limited our study to the first field (WE and safety), including when we refer to WE activities as HES activities.

Decentralization of responsibility is associated with the Internal Control (IC) reform. The first Internal Control Regulations covering the HES field for land-based work activity came in 1991, but was updated in 1996 (FOR-1996-12-06-1127). IC is a general principle used in many different areas and industries. It implies a duty to establish quality systems to ensure that the organization complies with requirements in legislation, such as in the WE Act (Graver 1995).

Internal Control of Health, Environment and Safety (IC HES) relocates the main focus from the (labor) inspection authorities to the enterprises themselves. HES activities are to be conducted locally and tailored to meet local challenges. The main responsibility rests with the employer. HES leadership is to be carried out by line management (not by staff personnel), as an integrated part of the entire managerial responsibility (Karlsen

2004, p. 3, 102). This makes line managers central HES actors. IC HES can thus be considered a management tool (Skaar 1994).

Employees also have the right and duty to take part in WE activities, including through participation in mapping work, risk assessment, action plan development, and HES activity implementation (Karlsen 2004). All enterprises with 10 employees or more must have at least one safety representative who is elected by and from the employees (LOV-2005-06-17-62). Participation in WE activities also includes reporting deviations, which is imperative in order to implement corrective measures (Karlsen 2010, p. 56, 84). IC HES can therefore also be seen as a process for promoting participatory democracy and learning (Karlsen & Lindøe 2006; Lindøe 2003; Skaar 1994).

Internal Control is associated with New Public Management (NPM) (Karlsen 2010, p. 17), a set of reforms from the 1980s which recommended changes in public sector based on role models from private sector. According to Klausen (2011, p. 53), NPM rests on two pillars. The first consists of economic reasoning; it promotes market solutions and emphasizes instruments such as privatization and exposure to competition. The second pillar is described as managerialism, and emphasizes new forms of organization and management, and new systems for financial management, budgeting, and accounting.

Based on this logic, results are to be reported to higher management levels and assessed against the organizations overall WE goals (Hippe & Trygstad 2012, p. 9). The basis for IC reform is a desire for less detailed regulations and for more emphasis on workplaces themselves finding ways to satisfy HES requirements. This form of *self-regulation*, which should also cut costs for the authorities, is the reform's central concept, one which shows the connection to the NPM tradition (Karlsen 2010, p. 17, 19).

Hospitals: institutional and organizational change

The Norwegian health care system is a National Health Service based on mandatory social insurance that is financed predominantly through general taxation. The main objective of hospitals is to provide quality health services to the population within an approved budget. Furthermore, the hospital should be a good workplace for employees.

Hospitals constitute a separate field of working life with their own history, culture, and institutional logic. They are large organizations consisting of many units and professions. Hospitals are described as professional bureaucracies (Minzberg 1989) characterized by both a far-reaching delegation of the decision-making authority and a substantial freedom to take action based on professional qualifications (Freidson 2001). Medical logic has traditionally dominated activity in hospitals, but this is now being challenged in several ways: through various national reforms, new perspectives, and competing logics.

About 20 years ago numerous NPM reforms were carried out in Norwegian hospitals, including effort-managed financing in 1997, unitary management in 1999 (effective as of 2001), free choice of hospitals in 2001, and The Hospital Trust Reform in 2002 (Hippe & Trygstad 2012, p. 28).

The Hospital Trust Reform caused hospitals, that were previously owned by county councils, to be taken over by the State and reorganized into hospital trusts. Norway is divided into four health regions with regional hospital trusts, which in turn own the local hospital trusts. One of the objectives was to create stronger political (State)

management of the hospitals and more efficient services. Another goal was to strengthen hospital leadership by increasing competence, role comprehension, responsibility, and implementation ability. The medical professions' power was to be limited so they would no longer be able to 'govern' the management (Iversen & Gammelsæter 2012).

Market thinking and bureaucratic organization, through new legislation and from management systems brought in from business, have ascended at the expense of the health professions (Freidson 2001). Health services have become subject to stronger external control and this has reduced the professions' autonomy (Brante 2005, p. 31). At the same time, hospital administrative management has grown stronger (Svensson & Karlson 2008). Professional authority is now being challenged by bureaucratic and economic authority.

Institutional logics can be understood as the principles used to organize businesses within different fields of society (Reay & Hinings 2009), and these principles are often linked to different knowledge and profession regimes. The introduction of a new business-like logic to health care challenges the dominant logic of medical professionalism (Reay & Hinings 2009). Each is associated with different organizational principles and each requires a different set of behaviors from actors within the field.

Hospitals are also workplaces affecting the health of many employees. There is a considerable range of risk factors and related health problems in European hospitals (Verschuren et al. 1995). Among the most consequential risk factors are injuries and accidents; exposure to chemical substances; and biologically contagious materials. Other important risk factors include adverse organizational, psychological, and social WE factors, such as time pressure, irregular work hours, conflicts with other employees, and proximity to sick and dying persons. A recent report of WE risks in Norwegian hospitals revealed that hospital staff were also exposed to role conflicts and high job demands combined with low job control (STAMI 2018, p. 208). All of these factors can be dangerous and indicate the need for systematic and comprehensive HES activities.

Methods

This article is based on a longitudinal, qualitative study conducted at three somatic hospitals (Hospital A, Hospital B, and Hospital C) in a Norwegian county (Borgen & Lunde 2007, 2009; Borgen 2014). The empirical material was obtained through two fieldwork studies conducted in 1998-1999 and 2013. Our research can be described as a time series study: a study aimed at analyzing how a phenomenon develops over time by interviewing various different but comparable selections (sample groups) about the same questions at different points of time. Time series studies describe changes at a group level, not at an individual level (Hellevik 1980, p. 375, 2001, p. 44).

Two strategic selections, each consisting of 18 informants with formal roles in WE activities, were interviewed. The hospitals were the same in both instances, but none of the informants participated more than once. Each of the 36 semi-structured interviews lasted for approximately one hour and was recorded, transcribed, and analyzed. In the period between the two fieldwork studies, Norwegian hospitals were reorganized. The sample groups were not the same with respect to the informants' position categories and professional base. Nonetheless, we consider the informants' functions to be so similar that the data can be effectively compared.

During the first fieldwork study, the hospitals were owned by the County council. We interviewed the managers in charge of the IC HES system at each hospital, representatives of the hospitals' central management and various staff functions, line managers at different levels, the hospitals' senior safety representatives, representative for the County administration (owner), and one representative for The Labor Inspection Authority.

The second fieldwork study was conducted after the hospitals had been reorganized into state hospital trusts. The three hospitals became part of two different hospital trusts. Hospital A and Hospital C belonged to a hospital trust called (in this article) 'The Fjord Hospital', whereas Hospital B belonged to a hospital trust called (in this article) 'The Mainland Hospital'. We interviewed the managers in charge of the IC HES system at each of the hospital trusts, representatives of the hospital trusts' management staff, line managers at different levels, the hospital trusts' respective senior safety representatives, and other safety representatives at various levels. We also interviewed a representative of the management at the regional health trust (owner), the head safety representative of the regional hospital trust, a representative of The Labor Inspection Authority, and a representative from the occupational health service at which The Fjord Hospital was a client. All interviews were based on informed consent.

The content of the Interview guides was essentially the same for both fieldwork studies in order to provide an accurate basis for comparison. The main topics included goals and strategies for the WE work, the level of local WE activity, the scope of the WE activity, the most significant WE challenges in the hospitals, and the factors with the most inhibiting or promoting effects on WE work. The interview guides were supplemented with new questions on an ongoing basis and were adapted to the individual informant. The second interview guide also contained questions based on findings from the first fieldwork study. Both authors participated in the first interview work, but only one of us in the second.

The interview analyses were based on a modified version of a four-step analytical procedure called *systematic text condensation* (Malterud 2011). In the first step, the researchers read through the interview in order to form an impression of the content. The text was then divided into preliminary themes. In our material, some themes were identical to the headings in the interview guides, such as 'Factors with an inhibitory effect in WE work'. Others were based on input from the informants, such as 'Quality management of health services and WE work'.

The second step was to identify the meaning-bearing entities. Key statements from the text were selected and placed together in 'code groups' with key statements from other interviews which covered similar topics (decontextualization). In our study, 'Factors with an inhibitory effect on WE work' was an example of a code group based on a preliminary theme. Meaning-bearing entities in this code group were 'lack of time, money and HES competence' and 'the hospital is an organization with "walls" between the professional groups'.

In the third step, a summary of the content in each code group was created using the informants' own words: for instance, the description of the hospital as an organization with 'walls' between the professional groups. The condensed text and some direct quotations then supplied material for the next step.

In the fourth step (recontextualization), we summarized the findings to provide new descriptions or concepts. For each code group, the researchers created a retelling of the condensed text, which was faithful to the informants, but written with analytical

distance. At this level, the description of the hospital as an organization with 'walls' between the professional groups, was described as poor communication between the different professions. The retelling was then illustrated using selected original quotations.

Under 'Results', we have chosen to present the empirical material under two headlines developed through the analysis process: *expansion of the scope of WE activities* and *decentralization of responsibility*.

Document studies are analyses of texts for the purpose of gathering information which would further illuminate the research questions. Policy decisions in the HES field of the County council and parts of the hospitals' own IC systems were made *sources and data* in the first fieldwork study. The documents provided information on the hospitals' official HES objectives and strategic thinking. Before the second fieldwork study, analyses of the health trusts' organizational plans and of the organization of the HES activities were performed in preparation for the interviews.

In the research process, we have emphasized openness to ensure reliability. Validity is assured by both oral and written colleague validation. Qualitative research aims to achieve *analytical* generalization (Kvale & Brinkmann 2009, p. 265). Our study offers a richer understanding of the WE work in hospitals, over and above the actual hospitals we study.

Results

The results of this study are presented in two sections. The first section is based on data that deals with the expansion in the scope of WE activities. The second section is based on data pertaining to the decentralization of responsibility. In each of the two sections, the findings from the first phase of the study are presented first, followed by the findings from the second phase.

Expansion of the scope of WE activities

Findings in the first part of the study (1998/1999)

The first part of the study found that most of the WE activities consisted of preventive work focused on physical and chemical factors. Conversely, health promotion activities in the psychosocial and organizational fields and work absences due to illness received minor attention. This means that the expansion in scope of WE legislation was only minimally incorporated. This is clear from both the interviews and the document studies of the hospitals' objectives and action plans.

The minor nature of these changes can be explained by the fact that physical and chemical factors have a quantitative character suitable for a system in which measures are often a reaction to deviations from established standards:

> The physical side is very simple in that it can be measured […] Either the [problem] is there and then you have to do something about it, or it is not there, and then everything is OK. You cannot measure the psychosocial field in the same way. There it is the individual feeling of how we are doing which counts, and this can be as different as the number of persons in a workplace. (Head of HR department, Hospital A)

Based on proposals from the employees at one of the hospitals, WE training of line managers and safety representatives was attempted aimed at health promotion in the psychosocial and organizational fields. They invited a recognized psychologist to give relevant lectures. However, the result was not as expected:

> Not so much came out of this stuff with the psychologist […], no activity came of it, it did not come up in the action plan saying we had to correct something. After a while people actually began to ask for the physical things again. (Head of IC HES system, Hospital A)

The absence of objectives, action plans, routines, and other documentation of health-promoting WE activities in the psychosocial field does not, however, tell the whole story. The interviews provided examples of line managers working actively on these matters, for example, taking care of employees with problems and ending conflicts between employees. The work could be comprehensive, but it went on informally and was not considered part of WE activities.

Neither was work on reducing absence due to illness particularly visible in the departments. Busy managers had more than enough to do in trying to reach temporary staff to substitute those who were ill, and they did not prioritize following up with employees who were off work due to illness. The head of the HR department in both Hospital A and Hospital B thought that many line managers failed at this element of WE activities, which made it harder to get them back to work.

Findings in the second part of the study (2013)

In the most recent interviews, the scope of WE activities more evenly encompasses prevention, health promotion, and fostering inclusive working conditions. Both employer representatives and employees agree on this. Preventive activities directed at physical and chemical factors still constitute an important part of WE activities at hospitals. But now health promotion activities in the psychosocial and organizational fields also get significant attention. As the senior safety representative at The Mainland Hospital Trust puts it, 'Psychosocial work environment: there we are really on the ball. That is perhaps the field where we are most on the ball.'

At all three hospitals, there were examples of employees having actively participated in improving WE activities at their workplace. At Hospital B, for instance, the employees were originally not satisfied with the general tone used among coworkers. This concern initiated a process that resulted in concrete rules for employee behavior and interaction in daily operations – rules that are still 'alive and well' in Hospital B. Later, other hospitals carried out similar projects. One of the safety representatives at Hospital C believed that employees felt more ownership of those processes that began from the bottom-up and of those rules that they themselves took part in developing:

> I think that these are completely local rules, I do not think they exist in the electronic quality system. […] The bottom line is ordinary manners and consideration for other people […]. I think we have a closer relationship to this, because it is something we have done ourselves. (Safety representative, Hospital C)

Another important finding is that the IA Agreement has made illness-based absence initiatives and inclusive conditions activities a focus area of the regional health trust's efforts to improve the hospital workplace. And these priorities are also more fully integrated into the collective WE work. Line managers must now report results to managers at a senior level, in accordance with the NPM tradition. Many of the informants thought that high costs connected to absence due to illness can explain some of the efforts being made. According to the senior safety representative of the regional hospital trust, absences due to illness receives a lot of attention from managers at all levels:

> The leaders who are committed and have knowledge about WE […] focus on other things than just inclusive working conditions. The leaders who do not have this knowledge – there I experience that WE activities are perhaps reduced to the completely clear requirements coming via the IA Agreement and also the completely basic safety routines concerning cuts, bruises, and that sort of thing. (Senior safety representative, Regional Hospital Trust)

The line managers' knowledge of and interest in WE activities does not, then, affect only the ability to be responsible for the WE; it also has a significant impact on the scope of WE activities.

Decentralization of responsibility

Findings in the first part of the study (1998–1999)

One of the main findings was that the level of local WE activity was *low*, even though it varied from hospital to hospital and between departments at the same hospital. The hospital owner (the County council) had established a common IC HES system for all the hospitals in the County. The IC HES system described the organization and the work distribution as well as the line managers' decentralized responsibility. Several informants thought that the IC HES system received much attention centrally but little attention locally. There was, therefore, no local activity that focused on the defined HES objectives: 'No. HES is dead in this department [….]. A lot of things come from the administration, but it is not on the daily agenda [locally]' (Departmental head nurse, Hospital A).

Some factors were predominant when our informants explained why the level of local WE activities were so low. Firstly, activity was hindered by a lack of time and competence. HES activities covered new and unknown tasks, and they were not often given priority in a hectic everyday working life.

Secondly, WE activities were often eclipsed by both quality management and financial management. The hospital professions were concerned with quality management of health services, while the hospital administration concentrated on the economy. WE activities appeared more or less to lack committed allies in the hospital:

> Quality management of health services has been more a professional thing than the HES regulations. It is more interesting for doctors and nurses to enter into this material than just going into the working environment. This is for the administrators to take care of […]. But if we look at the administrators, then I think that economy comes (first), economy is what gets the most attention in any case. (Informant, County Health and Social Services Department)

Even after becoming managers, leaders with backgrounds in the health profession often wished to continue their clinical work. The result was that many line managers were most loyal to those objectives which directly focused on the patients: 'We must get health professionals to act as managers when they apply for manager jobs, […]. They would rather be health professionals than managers' (Head of IC HES system, Hospital B).

Thirdly, WE results were not subject to the same oversight from the hospitals' head administration as were those concerning the areas of economy and quality management:

> You get punished if you do not have your accounts in order right down to the last penny. You can go to prison for this. But if something is happening in this part (HES), my impression is that nobody cares. Economy is Alpha and Omega. (Head of IC HES system, Hospital C)

Fourthly, characteristics of the hospital's *organizational culture* had a hindering effect on HES activities. Hospital employees were divided into a wide range of professions and trade unions, and little contact occurred across these professional boundaries. The senior safety representative at Hospital C, for instance, had work experience from the private sector, and described the organizational culture at the hospital as differing from industry—as an organization with 'walls' between the professional groups.

These 'walls' resulted in safety representatives, who were supposed to be responsible for ensuring the WE and safety for all employees, directing their attention primarily towards their own professional group: 'We assume in a way that the safety representative has channels to all the employees. When we check this out, it appears that this is not the case; it does not work like that' (Head of IC HES system, Hospital A).

'The walls' between the professions also made it difficult for those managers who were given multi-professional HES responsibilities to fulfill their obligations. Lacking authority over other professions hindered their ability to carry out their mandate: 'Some groups distanced themselves from these persons. Head nurses have this HES responsibility at Hospital A. They could not make this work in relation to the doctors' (Inspector, Labor Inspection Authority).

Findings in the second part of the study (2013)

The second part of the study was conducted after the hospitals had become health trusts, and after the reform of unitary management in hospitals was imposed by law in 1999 (LOV-1999-07-02-61). The main finding here was that local WE activities had increased, and a clear change had occurred regarding how decentralized responsibility was handled by line managers. HES activity became more systematic and more visible, through the use of firm routines for charting, the development of action plans, and the implementation of various measures. HES had become part of the accumulated responsibility for line managers, and it was progressively seen as closely connected to primary work tasks. The new generation of line managers acknowledged responsibility for both professional health management and general management, including WE activities. The safety representatives at the three hospitals noted that more time was being provided for WE activities, and an increased cooperation with their closest leaders.

The hospital's organizational culture was no longer perceived as a hindrance to cross-professional WE activities. Most employees considered IC HES to be just as suitable for hospitals as for other enterprises. One informant followed the development closely for more than ten years: 'The main impression here is that it is much better now […]. But this does not mean that the world is problem-free or that the picture is clear-cut' (Inspector, Labor Inspection Authority).

However, not everything functions equally well. There were significant variances in knowledge about the IC HES system—about its routines and utilization. The electronic IC HES system was not widely considered user-friendly, and this hindered local HES activity: 'It is embarrassing, I almost do not use the IC HES system. It is difficult to relate to […]. I do not think it is a user-friendly system' (HR advisor, Hospital B).

Many of the informants considered the electronic IC HES system so cumbersome that it contributed to the underreporting of deviations. As a result, the management's ability to implement corrective measures and the employees' democratic right to participation were reduced. This is a serious objection to the hospitals' IC HES system.

At all three hospitals, underreporting also was described as a reaction to the disregard shown for previous deviation reports which had not led to any corrective measures. One representative despondently remarked that 'nothing happens, it just goes on in the same way, there is just a bit of noise there and then, and then we are back to the same as usual. We have therefore had so-called deviation fatigue amongst people' (Safety Representative, Hospital B).

In 2013, quality management of health services had become an even bigger part of collective improvement work than it had been fifteen years earlier. Some informants thought that HES had been displaced by quality management activities, whereas others thought that HES activities benefitted from the shared logic and terminology. The quality management advisor at The Fjord Hospital Trust commented, 'perhaps quality management and patient safety took some of the focus which HES had as a management task. At the same time these may be two sides of the same coin'.

The leader for the HES section at The Fjord Hospital wished for more attention from top management: 'As I see it, it is mostly in formal, official settings that the working environment is emphasized as a prerequisite in order to deliver good quality services.'

Quality management of health services coincides more closely with employees' professional ideals than WE activity does, but there are also other reasons behind the strong position of quality management in the organization. In addition to national campaigns, The Fjord Hospital Trust carried out a major internal patient safety campaign, in response to a flurry of negative media attention due to a case concerning patient safety:

> The case resulted in considerable use of resources associated with patient safety and quality management, which HES activities never came close to. […]. When we got the new managing director it was very important for him that we improved the public impression of the situation here. People can be scared reading about these things in the paper. (Leader of the HES section, The Fjord Hospital Trust)

Moreover, quality management of health services, as opposed to WE activity, is emphasized in the authorities' task document. The Ministry of Health and Care Services sends out its Commissioner's Document to the Regional Health Trust, which in turn sends out a task letter to the various health trusts:

> The point is that not one HES requirement comes from the Commissioner's Document sent from The Ministry for Health and Care to the regional health trusts. […] and I think that already, at this point, one struggles a bit in relation to the head owner not setting any requirements for this area at all. We are basically outcompeted by all the requirements for patient safety and quality management by which we will be measured. (Head Safety Representative, Regional Hospital Trust)

The patient's right to choose a hospital (LOV-1999-07-02-63, §2–4) has led to hospitals competing for patients. A bad public reputation can mean reduced patients or funding, and thus top management has become more concerned about the quality of health services. This had traditionally been the foremost concern of the professions. Quality management and economy have become common criteria for owners, directors, and line managers with backgrounds in the health profession when assessing the hospitals' results. Despite clear improvements in WE activities from 1998 to 2013, it is still challenging for WE activities to compete for attention, time, and resources in hospitals.

Discussion

The expansion of the scope of hospital WE activities

The results presented in the analysis reveal that the scope of WE activities have changed from a major emphasis put on prevention of physical, chemical, and biological risk factors in the first part of the study (1998-1999), to a more comprehensive and balanced scope in the second part of the study (2013). The regulatory WE requirements are now more clearly reflected in the WE activities themselves. And these WE activities are also more evenly distributed between the three types of public health work: prevention, health promotion, and fostering of inclusive working conditions.

There may be several explanations for the expanded scope of hospital WE activities between 1998 and 2013. First, there have been changes in legislation in the period between the first part of the study and the second, which may explain changes in the purview of the hospitals' WE work. These changes arguably strengthened the public health science perspectives in the legislation, and they represent both a clarification and an expansion of the requirements in the legislation.

In addition, various declarations and agreements between concerned parties were signed during this period. Health promotion activities may have been bolstered by the Lillestrøm Declaration on Workplace Health Promotion (STAMI 2002), a Norwegian follow-up to the Luxembourg declaration (ENWHP 1997). The IA Agreement came into effect in 2001, and it has since established requirements for inclusive working life activities as well as helped expand the scope of WE activities. The IA Agreement has been renewed and updated several times, most recently in 2019.

From the first part of the study, we discovered that a lack of documented health-promoting WE activities in the psychosocial field does not give a true picture of the work actually being done. The interviews provided examples of line managers who worked quite actively, but informally, with these issues; the work could be extensive, but it was not considered part of the official WE activities and was thus not documented. Some of

the increase in the psychosocial WE activities in the second part of the study may have been due to a higher degree of formalization and documentation than before.

Our informants rarely used the public health scientific terminology from the Working Environment Act (such as 'prevention', 'health promotion work', and 'fostering of inclusive working conditions') when describing the content of the WE work, unless we used the terms first or asked them to elaborate on how they worked. The informants mostly referenced specific WE factors or problems (such as time pressure or sick leave), or categories such as psychosocial WE.

According to Madsen and Hasle (2017), the expanded scope may also have been the result of ideas and concepts from Human Resource Management (HRM), such as well-being and psychosocial WE, infiltrating WE work. Such a development has provided a new approach to WE activities, which up until now has been dominated by risk management.

Decentralization of responsibility and local WE activities

With regard to the implementation of decentralized responsibility for WE activities, this study shows significant changes during the period between 1998 and 2013. In the first part of the study, we found that the decentralization of responsibility, led to a low level of local activity; line managers were unwilling to adopt responsibility for WE work, even though the Internal Control Regulations (from 1991 and 1996) specified that responsibility for the WE fell on them, working in cooperation with the safety representative and other employees. The level of WE activities were low compared to the requirements of the WE Act, and the challenges within the hospitals WE. In the second part of the study, both leaders and safety representatives noted an improvement in how line managers handled their responsibility and indicated a higher level of WE activities than they had experienced previously.

These findings are in accordance with the results of the inspections by the Norwegian Labor Inspection Authority in 2005 and in 2008. In the beginning, the Labor Inspection Authority regularly found a dearth of systematic work on WE activities, a lack of forums for participation, and an imbalance between tasks and resources. The main challenges were the organization of work and the handling of WE problems. In the aftermath of the inspection period, they found that WE activities improved significantly since 2005—that they have come to occupy a more central position in the hospitals' daily work, and that safety representatives have strengthened their position as resources in WE activities (Norwegian Labor Inspection Authority 2016).

The requirement of unitary management (1999-2001) was a major change in hospitals between 1998 and 2013. Once health professions (mostly doctors or nurses) entered this new type of leadership role, involving a combination of professional health leadership and general management, they became known as hybrid managers (Berg et al. 2010). This managerial role is particularly relevant as a result of the NPM-inspired reforms in the public sector. More management tasks became assigned to the line manager, who was given a more complex set of responsibilities, including economy, professional management, personnel administration, and IC HES. These leaders have a large and comprehensive area of responsibility, one in which various different objectives and interests have to be accomplished in the daily work (Kamp 2016, p. 2).

According to Madsen and Hasle (2017), organizations tend to change their approach to WE activities, from treating it as an issue they deal with in order to satisfy external regulatory bodies or satisfy employee demands, to considering the WE as an issue in its own right that has to be managed in order to secure sustainable business practice and organizational outcomes. They argue that this shift marks a trend towards the 'mainstreaming' of WE activities, which are increasingly managed by organizations like any other organizational issue.

With all of their varied work tasks, new hybrid managers face demanding challenges. We have found that line managers seem to have become the real hybrid leaders who are attentive to the whole breadth of objectives in the hospital, but hybrid managers have not exchanged their identities as health professionals for new identities as managers (Kamp 2016, pp. 2–3). The complexity of a line manager's responsibilities puts different work tasks in competition. In the WE activities, the line manager has to cater to different public health approaches which sometimes compete with one another for attention. In addition, they must also consider other parts of the total HES activities (e.g., protection of the external environment against pollution) as well as their obligations vis-à-vis patient care, economy, personnel administration, and professional development. The same person becomes responsible for fulfilling the requirements of many different areas—some contradictory and often competing (Bakken et al. 2002).

The line managers, who previously had much in common with clinical managers, now seem to have more in common with neo-bureaucratic managers (Byrkjeflot & Kragh Jespersen 2014). The new hybrid manager role involves the combination of two competing logics: a new logic of business-like health care and the previously dominant logic of medical professionalism (Reay & Hinings 2009). The new managers thus have to handle the dissonance between co-existing and competing institutional logics.

WE activities emphasize the health and well-being of the employees, but because this work still enjoys less prestige in the hospital than medical treatment and economy, it is often given lower priority; economy and the quality of patient care remain the most important considerations. In these areas, the hospital owner (Regional health authority and the State) demands reporting and control is strict. The responsibility for supervision in the HES area lies with supervisory authorities other than those in the health profession. HES and WE issues are less valued and, thus, often fail to compete for time, resources, and attention.

Systematic HES activities represent both the written formalization and bureaucratization of the line manager's responsibility. IC HES is a management system for the employer in which documentation and the reporting of results higher up the chain of authority follow predefined formal requirements. In the second part of the study, the electronic IC HES system was criticized as not being user-friendly, and the lack of feedback from managers regarding reported deviations reduced employees' motivation to participate in the WE work. Hospitals' electronic IC HES systems appear to be more of a barrier than an effective tool for contributing to greater local WE activity. Use of the IC HES system can be regarded as a bureaucratic obstacle in WE activities, and neglected follow-up of reported defaults and deviations on the part of the line manager can create discontent and low motivation among employees.

The position of the line manager seems to be both important and challenging. In a study of predictors of job satisfaction among doctors, nurses, and auxiliaries in Norwegian hospitals, the only domain of work that significantly predicted high job satisfaction,

which proved to be important for all groups, was the positive evaluation of local leadership (Krogstad et al. 2006). While they can be an important source of affirmation in the workplace, line managers can also, according to Hovden (1995), be scapegoats who directly experience conflict between short-term production requirements and HES activities. 'Scapegoating' is described as the identification, blaming, and punishing of individuals for problems that rightly belong to the larger organization (Dyckman & Cutler 2003).

The level of local activity is also affected by the employees' motivation for co-involvement. It is uncertain whether the professions consider IC HES to be an important channel for participation. Employees in the health professions seem to have a different starting point than those from industry. For the latter, participation was aimed to provide industry workers with a more meaningful employment situation in the form of professional responsibility, learning, personal development, and decision-making. In contrast, health professions, especially the medical profession, have held an independent position with regard to hospital management. The benefits of increased participation in WE activities can, therefore, be less apparent to the health professions.

Conclusion

This article has analyzed how two development traits in regulatory requirements for WE activities—an expansion of scope and a decentralization of responsibility—are understood and handled over time by actors responsible for WE activities at three hospitals in Norway. The article is based on a longitudinal, qualitative study conducted in 1998-1999 and 2013. The longitudinal design of the study has made it possible to assess stability and change over a period of 15 years.

In the first part of the study, systematic WE work had few allies, either among health professionals or administrative staff. The second part of the study showed that the combination of the IC HES reform and unitary management has imposed line managers to take responsibility for the systematic WE work. Both the scope of the local WE work and the level of activity in the hospitals have increased. The overall effect of the two development traits was that the main responsibility for highly comprehensive and complex WE activities has been assigned to a new category of line managers.

Most of all this study show that implementation of reforms in hospitals takes time. An explanation may be that hospitals are large, public institutions with an established organizational culture and many different tasks to attend to. Another possible explanation could be that WE work has low prestige in hospitals compared to economy, medicine, and quality management of health services. WE work has become a clear responsibility for line managers, which they recognize. At the same time, these leaders have been given a wide range of areas of responsibility. WE and other HES tasks must fight for attention and resources in relation to other fields that have higher prestige. WE work often still struggle to be prioritized.

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