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Navigating Decommissioning in a Local Healthcare System

Leadership perspectives

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Abstract
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Decommissioning in healthcare serves multiple purposes beyond achieving economic efficiency, including the planned removal and reassessment of services to facilitate more effective care and treatments. Despite their importance, decommissioning processes face challenges due to resource scarcity and are at a higher risk of failure compared to other service changes. To understand how decommissioning programmes unfold in healthcare, more empirical studies are required. Region Dalarna in Sweden initiated a decommissioning programme with the intention of achieving budget balance, a decision driven by a long-term budget deficit. The executive leadership team empowered healthcare managers to propose changes by giving them significant decision-making opportunities. After a period of two years, the programme had achieved positive outcomes, including enhanced economic efficiency, improved patient care and increased staff motivation. The aim of this thesis was, therefore, to provide evidence on critical factors perceived by politicians, public servants, and healthcare managers crucial for the successful implementation of a large-scale decommissioning programme. The study employed a combination of qualitative and quantitative methods across four empirical studies. Study I used interviews with department managers to identify what made successful decommissioning implementation possible. Study II involved interviews with members of the executive leadership team, including six political leaders and twelve public servants, to gather insights on effective decommissioning. Study III used a cross-sectional survey to compare perceptions among department and unit managers regarding leadership, participation, and responsibility. Finally, Study IV adopted a mixed-methods approach, incorporating interviews and surveys with department managers to examine the practical application of a prioritization model during the decommissioning programme. In study I, results indicated that successful implementation relied on credible problem framing, early involvement of healthcare managers, and clinical champions in the region´s leadership. Study II identified seven critical factors for facilitating decommissioning, emphasizing robust evidence and a cultural shift toward responsible resource use. Study III revealed dissatisfaction among unit managers regarding leadership support and participation, suggesting a need for improved involvement. Study IV showed that while the prioritization model was generally perceived positively, its implementation faced challenges, including time constraints and inconsistent acceptance. Overall, the findings provide valuable insights and highlight the complexities of navigating decommissioning programmes.

Keywords: Decommissioning, Healthcare managers, Large-scale changes, Politicians, Public servants

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To my colleagues, whose hard work and commitment are the heart and soul of our healthcare system.

List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

I. Gustafsson, IB., Winblad, U., Wallin, L., Fredriksson, M. Factors that shape the successful implementation of decommissioning programmes: an interview study with clinic managers. *BMC Health Serv Res* 21, 805 (2021).

II. Gustafsson, IB., Wallin, L., Winblad, U., Fredriksson, M. Putting a decommissioning programme into action: an interview study with politicians and public servants in a local healthcare organisation. *J Health Organ Manag.* 2024 Jul 19;38(9):258-279.

III. Gustafsson IB., Wallin L., Winblad, U., Fredriksson, M. Implementing a Decommissioning Programme in Swedish Healthcare: Experiences of Healthcare Managers. *Health Services Insights*. 2024;17.

IV. Gustafsson IB., Wallin L., Winblad, U., Fredriksson, M. Department managers´ perception of using a priority-setting model in a local healthcare organisation: A mixed methods study. *Manuscript.*

Contents

Introduction

Between 1996 and 2014, Region Dalarna experienced recurring budget deficits. In the beginning of 2015, the economic prediction for the healthcare services projected a deficit of SEK 320 million for the year. The executive leadership of Region Dalarna, represented by politicians and public servants (non-clinical and clinical), decided that, by 2019, 700 million SEK had to be cut in order to balance the budget. The executive leadership decided to develop a detailed change plan, which in this thesis is referred to as the *decommissioning programme* with a strong message to "provide the local healthcare system in Region Dalarna with the conditions to, within the allocated budget and based on medical developments, be patient-safe, sustainable and of high quality" (1). As will be described more in detail in section, Decommissioning in Healthcare, decommissioning refers to the planned removal, reduction and replacement of healthcare services and interventions.

As a start of the decommissioning programme, a comprehensive review was compiled of, for example, the region's quality of care, costs, staffing, capacity, population and public health, accessibility, and effectiveness as well as revenues. The review report focused on Region Dalarna's healthcare system but included comparisons with other regions in Sweden. It illustrated that Region Dalarna had high costs and simultaneously a low productivity (1). After an intense and inclusive process, a programme containing a large number of decommissioning proposals to solve the region's financial problems was presented. In this process, department managers (*verksamhetschefer*), but also unit managers (*första linjens chefer*) and healthcare professionals, were extensively involved by suggesting and discussing potential savings and changes.

There was remarkably little resistance from the department managers and clinics involved in carrying out the decommissioning activities considering the extensive changes they had to accomplish (2, 3). The changes included, for example the removal of satellite primary care centres in rural areas, and a reduced number of outpatient clinics for paediatric care and mental health care. In fact, almost 95 percent of the 150 decommissioning activities in the programme were implemented at the end of 2016. It was also reported that the

region's economy showed positive signs, with almost half of the planned savings (49%) being achieved, halfway through the programme (4, 5). There were also indications of a positive trend in quality of care for the divisions of primary care, surgery, and medicine during the decommissioning processes, as well as in indicators of patient safety (6). Furthermore, an employee survey showed improved results regarding work motivation and the perception of the region's leadership (7). Additionally, in 2020, a national evaluation reported that Region Dalarna had the lowest healthcare cost per inhabitant among Sweden's 21 regions (8). In conclusion, most evaluations showed that the implementation of the decommissioning programme progressed with positive outcomes, which indicated that the decommissioning processes overall were successful. Drawing on the policy implementation literature, this result could be seen as both an operational success and outcome success, measured in the midst of the decommissioning programme´s implementation (9). The implementation of numerous decommissioning decisions and the little resistance from clinics to these changes indicate operational success. The financial situation improved, and the quality of care was unaffected, which are two key indicators of an outcome success. Nonetheless, there may be outcomes that were experienced less successful, for example, among the population in more rural areas that lost previous healthcare services (10), and also uncertainty about the long-term impact of the decommissioning programme (11).

The executive leadership in Dalarna, consisting of region politicians and public servants (non-clinical and clinical), decided to follow the implementation of the decommissioning programme through a scientific study focusing on the development of the programme and how the changes were implemented in practice. This PhD project is part of this research project, carried out by researchers at the Department of Public Health and Caring Sciences, Uppsala University.

The decommissioning programme constitutes the empirical focus of the thesis and focuses on the perceptions of the leadership, that is healthcare managers (department and unit managers), politicians, and public servants. At the start of the research project, the decommissioning programme had been running for about two years and was viewed as 'successful', as previously outlined. In light of this, the primary aim of this thesis was to identify and increase the understanding of factors considered crucial by healthcare managers, politicians and public servants in their efforts to implement the large-scale decommissioning programme in a patient-safe, sustainable and effective way. Whilst the emphasis is placed on the optimising factors, the studies draw on a range

of experiences and perspectives from healthcare managers at multiple levels within the healthcare system.

Background

Resource scarcity has always been a challenging issue for healthcare systems, even in wealthy countries. This is due to a number of factors, such as demographic changes and technological and medical innovations, which can lead to significant cost increases (12). In order to address these issues, health care systems implement various strategies, including prioritisation, and cost-cutting in personnel and material resources (13, 14).

In democratically governed healthcare systems, politicians make overarching decisions regarding resource allocation. However, the distribution of resources among various patient groups and treatment options is typically managed at the clinical level, such as within different hospital departments. It is essential to recognise that health equity is affected by these decisions as well (15). Making decisions about resource allocation is a complex task for health care managers, as decisions must be based on regulations and guidelines. For example, in Swedish health care, decision-makers, including unit and department managers, are required to consider and follow the national ethical guidelines on priorities when allocating resources within their clinics. The guidelines state that a greater proportion of resources should be allocated to the care of those most in need (16). This is a challenging duty, and researchers report a perceived need for support at all professional levels in the difficult process of prioritising in the presence of scarce resources (17, 18). The incorporation of research-based evidence into the decision-making process is another complex issue. It is the responsibility of healthcare managers, to organise, provide, and ensure that care is knowledge-based (19). However, research has shown that public servants and healthcare managers may rely on local, unofficial data, a practice that has the potential to compromise the principles of equity and effective health care (20). In order to manage large budget deficits in health care, it is essential to understand the perceptions of healthcare managers regarding how best to achieve sustainable changes. Studies have focused on politicians and public servants' involvement in cost-saving measures in healthcare, but clinic-level managers' experiences are less explored (21-23). These individuals play a central role in communicating, supporting and implementing change, while adhering to policies and ensuring that decisions are based on available knowledge (19, 24).

Healthcare managers

In a real-world setting, healthcare managers (*verksamhetschefer och första linjens chefer*) are the expected communicators of all kinds of resource allocation decisions in their clinics, and the primary initiators of implementing sometimes unpopular decisions, such as those involving decommissioning (24). In Sweden, department managers (which are often physicians or nurses) are always accountable for patients' continuity and coordination and for patient safety (15). First line managers are often responsible for decision-making processes that impact the allocation of resources such as time, money, and personnel within their units. They function as street-level bureaucrats, translating both national and local policies and directives (for example decommissioning programmes) into day-to-day actions, navigating competing interests and tensions (25).

Resource allocation and issues of care quality has been considered a source of ethical problems in, for example, nurse managers' work, as the ethics of nurse professionals is perceived to have limited value. Additionally, the importance of guidelines, training, and a shared framework for addressing ethical concerns in practice and management has been emphasised. Such measures could help ensure that high-quality care is sustained even in the face of decommissioning activities (26). Although such frameworks aim to facilitate the sometimes contentious decision-making about resource allocation (19), scholars report that managers demonstrate distress when decisions are performed at their clinics in a way that does not harmonize with their professional values and their responsibility as managers to ensure, for example, patient-safety and continuity (27). Formal training with priority-setting frameworks does not always make it easier for managers to cope with distress; instead priority-setting training has been to shown to reveal and raise awareness of ethical dilemmas that in some cases entail managers ending their assignments (28).

Politicians and public servants

The relationship between politicians and public servants in priority-setting during decommissioning processes constitutes a complex interactive dynamic that necessitates a diverse range of competencies. It is essential to assess and balance the contexts in which political engagement is both necessary and beneficial, thereby enhancing decision-making. Moreover, the interactions among politicians, public servants, and the healthcare profession in decommissioning activities rely heavily on social skills, commitment, and ensuring access to comprehensible information (21, 29). In the context of decision-making, particularly in processes such as decommissioning, the

interplay between politicians and public servants occurs within what could be illustrated as the 'purple zone'. This zone represents a blurred boundary between the political 'red zone' and the administrative 'blue zone', suggesting the absence of a definitive separation between politics and administration. Public servants operate within this intermediary space, where they play a crucial role in facilitating and supporting politicians throughout the decision-making process. They do this by ensuring that accessible and comprehensible information is available, while also employing their specialized knowledge and administrative skills to foster an interactive working relationship with political leaders (30). The 'political cycle' refers to the context in which public servants operate, where working processes often have a recurring pattern and rhythm that leads to, for example, new policies. Public servants must navigate these cycles carefully. For instance, during a financial crisis, public servants may introduce decommissioning decisions as part of a broader political response (31).

The Swedish healthcare system

In Sweden, healthcare responsibility is distributed across three political governing levels: the national government, the regions, and the municipalities (32). All three levels are democratically elected every four years. The central government oversees overall health and medical care policy, while local and regional authorities manage the provision and financing of healthcare services. Each of the twenty-one regions operates with an independent budget and is accountable for delivering and funding the majority of healthcare services, with approximately 75% of costs covered by income taxes from regional residents. Consequently, the Swedish healthcare system is characterized by a strongly decentralized structure. The governance of the healthcare system across multiple geographical levels complicates its structure and can lead to an unclear division of responsibilities (33). There is also a constant interplay of power and control between politicians, public servants and healthcare professionals (34). In order to exert influence over regions and healthcare services, the government applies a range of different steering mechanisms – from hard to soft – such as legislation, supervision, economic incentives, agreements, monitoring and evaluations. The overarching legal framework is the Health and Medical Services Act (2017:30), which stipulates that the objective of health and medical care is to ensure good health and care on equal terms for the entire population (15).

Swedish healthcare is generally of a high standard. Nevertheless, there are sectors in which regional disparities emerge, resulting in variations in the

quality of care and accessibility of services across the Swedish population. To address these challenges, many national initiatives have been introduced with a view to improving equity and access within the Swedish healthcare system and the twenty-one regions. It is also the rationale behind many proposals for reform, not least the ongoing inquiry (*Vårdansvarskomittén*) into the conditions for a gradual and long-term introduction of full or partial national responsibility for health care (35). To mention some other examples, the regional inequities were identified as a main catalyst for the development of a knowledge-based management system introduced in Sweden 2017. As part of this system, national groups formulate "clinical pathways", which describe the assessment, diagnosis, planning, and evaluation procedures for specific conditions (patient groups) prioritised for implementation at the regional level (36). Another national initiative is the waiting-time guarantee which stipulates a legal entitlement that defines the timeframe within which care should be provided (15, 37). For example, you should have a primary care contact on the day you seek care, and a medical assessment within three days and 90 days for surgery, regardless of the severity of your condition. Economic compensation is frequently used to reinforce national initiatives and legislation, with requirements to be fulfilled by the regions (38). Nevertheless, the unintended consequences of well-intentioned policies and legislation may be that other, more seriously ill patients are crowded out (39) in order for the regions to fulfil the national requirements and receive the financial compensation. This poses a significant dilemma for healthcare managers, who find themselves navigating a complex landscape of professional ethics, national policies, laws and requirements. At worst, the implementation of national initiatives has the potential to hinder and undermine the efforts of regions to address their local financial problems. For example, concurrent with the implementation of the decommissioning programme in Region Dalarna, a significant national primary care reform was developed and initiated. The reform aimed to facilitate the transition into a more modern health care system, providing patients with coordinated care centred around primary care centres, a change that would require a shift of resources from specialised to primary care (40).

Decision-making in the regions

The regions are governed by politicians who are directly elected by those residing in the region. This takes place through elections every four years. The regional assembly (*regionfullmäktige*) is the highest decision-making body at the regional level and represents the population and makes decisions on the region's most important issues. One of the regional assembly's most important tasks is to make decisions about the region's direction, activities and economy.

For example, the regional assembly makes decisions about the budget and tax rate. They also decide on the region administration's organization and forms of operation. A number of regional councilors (*regionråd*) are responsible for presenting issues in the regional assembly and are also obliged to answer questions and interpellations. There are also regional councilors in opposition.

The regional assembly can delegate certain matters to the region executive board or other committees, which also have political assignments. The regional executive board leads and coordinates all work within the region, and it is responsible for the region's finances. Between the regional assembly's meetings, the regional executive board leads the political work. Furthermore, politicians work in various committees that have different areas of responsibility, a common example is a health and medical care committee. Since the regions themselves decide which committees they want, the organizational set up is different throughout Sweden. All issues that come to the regional assembly are prepared in one of the committees. In practice, however, it is public servants who handle the actual implementation of the region's activities, even though the elected representatives always have the ultimate responsibility. Each committee has an administration that assists the committee with supporting documents and ensures that the politically made decisions are implemented. Each administration is led by an administrative manager. There is often a region office which is controlled and led by the region director (*regiondirektör*), whose task is to control, support and coordinate the region's activities. The administration works to implement goals and assignments decided by the regional assembly, the regional executive board and committees.

As will be described more in detail in the section, Decommissioning in Region Dalarna, the regional assembly as well as the regional executive board stood behind the proposed decommissioning programme in Region Dalarna (41). However, the programme did not only contain the decommissioning activities decided by the politicians but also activities worked out by the department managers and public servants.

Austerity and welfare services

Financial crises can be of different magnitudes and be limited to a certain sector (such as healthcare) or pertain to whole countries. The financial crises that began in 2007 forced many countries to choose between investing in economic growth initiatives or implementing austerity measures involving spending cuts and tax increases. It is important to note that vulnerable populations, including those facing unstable employment, inadequate housing or pre-existing health

conditions, were disproportionately affected by these measures. For example, austerity has been linked to a decline in mental health and an increase in suicide rates. However, the impacts were not uniform; countries with strong social protection systems, such as Iceland and Germany, fared significantly better during the crisis compared to those with weaker systems, such as Greece (42). Austerity is a contentious policy area that significantly influences economic discussions, particularly during crises. The repercussions of such actions can be long-lasting, as evidenced by the EU financial crisis. Research indicates that strategic selective cuts can mitigate the negative impacts of crises, rather than broad, undifferentiated reductions (43). Scholars have examined austerity measures in the context of the Swedish welfare system, focused on the shift from national sickness insurance to municipal social assistance and personal assistance for individuals with disabilities. The results highlight the vulnerabilities of municipalities under national austerity, which bear ultimate responsibility for marginalised groups. Furthermore, variations among municipalities, including differences in size and economic conditions, contribute to increased inequalities in service provision (44).

As mentioned in the background, resource scarcity is always a challenging issue for healthcare systems, also in periods without an overall financial crisis, leading to the use of different strategies, including prioritisation and cost-cutting in personnel and material resources (13, 14). This has led to an expanding research literature on how to deal with resource scarcity. This should be of relevance for the Swedish regions today as most of them report negative results and need to restructure their services in order to balance their budgets and be able to provide the services their residents need.

Decommissioning in healthcare

In recent years, there has been an increasing interest in the concept ‘decommissioning’. It is used, as an umbrella term, to describe the plethora of activities adopted by healthcare systems to address limited resources and constrained budgets in both national and regional contexts (2, 3, 10, 11, 45-51). The term itself is multi-faceted, extending to different discourses and academic disciplines. Notwithstanding the absence of a clear place in the discourses of the welfare state, this may be of secondary importance, as the term and its content are, in many ways, practical and useful in the real world of healthcare systems in their efforts to make ends meet. As demonstrated in the case study outlined in this thesis, the decommissioning activities in Region Dalarna encompassed a broad spectrum. These activities included, for

example, the complete closure of several health care facilities, task-shifting among health care professionals, and the implementation of new, more efficient ways of working and delivering services (46) .

Decommissioning processes are in many ways like other complex change processes in healthcare but also involve the aggravation of being initiated as a response to resource scarcity (48). The process of decommissioning represents a natural component of the commissioning of healthcare services. In addition to its economic purpose (i.e. the achievement of affordability of the services offered), it may serve other purposes. In the literature, the explicit aim of decommissioning is broad and referred to as the planned removal, reduction and replacement of healthcare services and interventions. This may involve re-evaluating existing services and generating space for those that are more effective and beneficial for patients. Services might be outdated, as patients and their needs change, and new innovations, modern technology, and new approaches to meet patients´ needs are constantly under development. Therapies may also be restricted by practice guidelines or the application of eligibility criteria or withdrawn by service reconfiguration (48, 49).

The scope of decommissioning can be diverse, ranging from the withdrawal of specific treatments options to large-scale decommissioning programmes such as the one explored in this thesis. It is not unexpected that a decision to withdraw a single intervention is a process which can be more straightforward than a decommissioning programme involving a significant part of a healthcare system (49). Facilitators may also differ between decommissioning cases. In some cases, relational skills have been identified as being critical to achieving the intent of decommissioning activities (2, 3), while in others, they have been found to be less important and more of a managerial procedure (49). In the context of discussions concerning the allocation and prioritisation of resources, there are numerous closely related concepts that are frequently referenced, yet navigating these concepts can prove challenging. According to the ethical platform established by the Swedish parliament in 1995 (consisting of the human dignity principle, the needs-solidarity principle and the cost effectiveness principle) (16), it is constructive to consider that only conscious choices that are guided by the ethical platform where the reasons for the decisions are openly available, should be considered as transparent prioritisation decisions in a Swedish healthcare context (52).

The commonly used concept ’disinvestment’ is usually considered as some sort of reduction or removal of health technologies supported by cost-effectiveness analysis of technologies and clinical practices, for example, diagnostic tools,

implantable devices, vaccines or medicines (53, 54). A relatively recent addition to the field of research is the concept of 'de-implementation'. This term is defined as the discontinuation or abandonment of practices that have not been proven to be effective, are less effective or less cost-effective than an alternative practice, or which may even be potentially harmful (55). The issue of 'rationing' is another potential outcome that may arise to handle financial difficulties. However, it should be noted that not all reductions in healthcare are necessarily indicative of rationing. It is possible that such decisions may be driven by the need to adapt to a changing healthcare landscape (52).

Furthermore, the broader literature on welfare state retrenchment offers insights into the sometimes sophisticated political strategies used to communicate and organise welfare cuts to avoid criticism from voters or interest groups seeking to obstruct change. A summary of such strategies infers that obfuscation could be one way to hide information, intentions and perceptibility of withdrawal healthcare services, to avoid blame (14). The responses to the stressed financial situation in Region Dalarna, as outlined in this thesis, could also be categorized in a number of ways according to cutback literature (9). Firstly, the use of operational cuts, such as a hiring freeze or task-shifting. Secondly, decisions to close units could be categorised as programme cuts. Finally, structural reforms may refer to new work methods and processes (46).

Decommissioning decisions such as reducing or withdrawing healthcare services are often a demanding due to the resistance from stakeholders, for example, the population and institutions affected by the decisions (47, 54). Despite resistance and obstacles, healthcare organizations must undoubtably review their services to be able to deliver care within allocated budgets (56). Experts in a Delphi panel developed a framework on drivers that ought to inform decommissioning processes and implementation. Thirty international experts contributed their perspectives through Delphi rounds to inform the development of this framework on decommissioning processes. The Delphi process enabled the identification of three key factors that should guide decommissioning processes: quality and patient safety, clinical effectiveness, and cost effectiveness. The consensus among the experts on best practice in decommissioning could be divided into three groups: change management and implementation; evidence and information; and relationships and political dimensions (51). These three groups encompassed approximately 30 factors that were considered facilitators in the decommissioning of healthcare services and were used as an analytical framework in study I and II, Table 1.

Table 1. Framework by Robert et al. (2014) rating factors (subcategories) in descending order, in terms of importance within each category, in shaping the extent to which decommissioning is implemented as planned.

Change management and implementation strategy	Evidence and information	Relationships and political dimensions
• Strength of executive leadership • Strength of clinical leadership • Quality of communication • Clarity of specific aims and objectives at start • Extent of cultural and behavioural change • Attention throughout to human aspects of process of change • Quality of project management • Availability of resources to support decision-making and implementation processes • Quality of strategic planning • Training and preparation of staff • Clarity of incentives and levers to support change • Complexity of decommissioning programme • Pace of change	• Demonstrable benefits • Clarity of evidence/data to support business case • ongoing monitoring and impact assessment • Clarity around new patient pathways • Review/evaluation of process • Availability of alternative services • Extent of adoption elsewhere of new intervention/service	• Clarity of rationale/case for change • Nature and extent of clinician engagement/involvement • Level of political support • Transparency of decision-making process • Nature and extent of patient/public engagement/involvement • Quality of partnership working with relevant agencies • Extent to which challenges vested interests • Nature and extent of media coverage • Stability within the local health economy during transition • Reputation of existing providers • Meets community expectations

Priority setting

The distinction between decommissioning and the closely associated activity priority setting is that the latter, may or may not play a part in decommissioning processes, but does not necessarily involve the withdrawal or reduction of healthcare interventions, as is often the aim of decommissioning (48, 49).

Decision-making in decommissioning processes, through priority-setting procedures, is a specific way of transparently handling resource allocation and cuts in healthcare systems (13). This occurs in many contexts in healthcare and can have multiple aims and designs. A considerable amount of research has focused on studying prioritization processes and decision-makers' strategies to prioritize different services, treatments and patient groups (19, 57). Although priority setting is highly desirable in order to balance resources to achieve equity and increase health growth it can be an emotionally challenging process (58, 59).

Healthcare priorities are established at various levels within healthcare organizations and are pertinent to multiple stakeholders (13, 19, 57). For instance, priorities articulated in evidence-based national guidelines provide essential support for healthcare professionals in their practices (60), while other priorities may be determined by political considerations and be less substantiated by evidence (61). It has become increasingly clear that many procedures involved in priority-setting encompass more than just technical and administrative aspects. A supportive climate of trust—marked by access to pertinent information and evidence—is crucial for building relationships among stakeholders and for reaching consensus in the complex decision-making processes associated with prioritisation (21, 29, 57, 62, 63). Moreover, the concept of legitimacy plays a central role in priority-setting processes, encompassing both procedural legitimacy, which relates to the methods and individuals involved in decision-making, and substantive legitimacy, which relates to the acceptance of the decisions' outcomes and content (22).

In resource allocation and decommissioning decisions, priority-setting frameworks could contribute by providing procedural transparency and be a first step to enhance decision-making (62, 64). Although many frameworks have high ambitions, such as improving the allocation of available resources and maximizing general health, difficulties in finding appropriate health improvement variables to measure the impact of frameworks in priority-setting remains (65, 66). In addition, priority-setting models and tools have shown limited use in routine praxis and raised concerns about how to increase their adoption. The need to develop, evaluate and summarize the strengths and limitations of each approach has also been established, to ensure and facilitate policymakers' opportunities to choose the most suited approach or tool for their specific priority-setting context (67). In a crisis, prioritization may be more of a forced ad hoc process that due to extreme stress, such as during the COVID-19 pandemic, helps test the resilience and reconfiguration abilities of healthcare services (68). After the pandemic, the use of priority-settings tools

may be more relevant than ever as the requirements to return to the same resource allocation as before may no longer exist (69).

The National Model for Transparent Prioritisation (NMTP) was a tool introduced during the implementation of the decommissioning programme in Region Dalarna to facilitate transparent prioritization and achieve fair priorities. The starting point for the NMTP was the ethical platform established by the Swedish parliament in 1995, consisting of: the human dignity principle, the needs-solidarity principle and the cost effectiveness principle. The NMTP aims to increase the systematic application of the ethical platform to ensure that a greater proportion of resources are allocated appropriately and efficiently to those in greatest need. The NMTP may be used for both vertical prioritizations i.e., choices within a disease category or horizontal prioritization i.e., choices between clinics in a region. But horizontal priorities could also occur within a clinic, when different professions outline their respective priorities and then compile a common rank within e.g., an outpatient care clinic or a primary care centre. The NMTP builds on a qualitative weighting of the severity level, patient benefit, cost-effectiveness and strength of evidence (70).

Decommissioning in Region Dalarna

Region Dalarna in Sweden spans 28,030 square kilometres, making it the fourth largest region in the country despite its sparse population of approximately 300,000 inhabitants, representing only 3% of Sweden's total population. This geography complicates access to healthcare services and consistently remains an important point in discussions amongst the executive leadership team regarding how to ensure accessibility, patient safety, and emergency care, especially when healthcare facilities can be a half-day journey away. This also puts a constant pressure on the region's finances.

The regional assembly (then the county council assembly) decided in November 2014 that an action plan for balanced finances in healthcare would be presented in June 2015. The background was that the economic development of healthcare had gone in an undesirable direction during 2014–2015, which is why additional and rapid measures, with effect in 2015, needed to be taken. The forecast for 2015 was minus SEK 320 million. A structure and change plan was proposed to reduce costs. The proposals presented that extensive work had been done together with department managers and with the participation of union representatives to, based on a review of demographics, quality of care, cost and staffing levels, develop a structure and change plan for

healthcare. Parts of the structure and change plan were for the regional executive board and the regional assembly to decide on, while other parts consisted of public servant decisions (41). The overall effect was estimated to reduce costs in 2015 by approximately SEK 140 million, in 2016 by a further SEK 340 million, and for the entire plan period, up to and including 2019 by an additional approximately SEK 70 million per year to a total of approximately SEK 700 million for the plan period. Examples of decommissioning activities decided on by politicians can be found in Table 2. In addition to these decommissioning activities, a number of activities were decided on by public servants and by healthcare managers, Table 3. In total, the attempt to balance the budget included a combination of operational cuts (20%), programme cuts (42%), and structural reforms (38%) (46). Examples of operational cuts include hiring freezes and eliminated positions, of programme cuts closed service units and facilities, and of structural reforms the introduction of new work methods and work processes such as The National Model for Transparent Prioritisation (NMTP) (70).

A fundamental starting point for the suggested decommissioning activities decided on by the politicians was that patient safety could be maintained. Another was that healthcare had to change in order to maintain good quality in line with medical developments. This meant that the distance to certain care interventions would become longer. A number of consequences were mentioned, such as increased environmental impact from longer patient transports, while public health was not considered to be affected, nor was equal treatment, since patients with the same medical needs were more likely to receive equal care when care is coordinated and takes place in fewer places. Regarding employee perspectives and the work environment, this meant that each change would be handled locally and that risk and consequence analyses, such as the employee perspective should be established. In the event of redundancy, employees should first be offered other work within their own division.

The region council decided with 49 votes in favour to 29 against (five members abstaining) to approve the proposal. The region council members of the Moderate Party, the Liberal Party, the Christian Democrats and the Dalarna Healthcare Party reserved their positions against the decision in favour of their own proposal. The regional council members of the Social Democrats, the Left Party and the Centre Party voted for the proposal.

Table 2. Examples of decommissioning activities decided on by politicians.

Service area	Decommissioning activity (driving distance)
Ambulance services	Ambulance station in Rättvik closed, stationed in Leksand (21 km)
Children's health care	Children's clinic in Ludvika moved to Borlänge hospital (43 km)
	Children's clinic in Borlänge hospital moved to Falun (20 km)
	Children's clinic in Avesta moved to Falu hospital (69 km)
Habilitation	The special pedagogical unit Hästberg closed
	Habilitation unit moved from Hedemora to Avesta
Surgery	Skönvikt overweight unit closed and moved to Falu hospital (43 km)
	Rehabilitation- and training pools at Falu hospital closed
	Rehabilitation- and training pools at Mora hospital closed
	Skin treatment unit in Malung closed
	Surgery unit in Ludvika moved to Borlänge (43 km)
	Otolaryngology Unit (Ear, Nose and Throat – ENT) in Borlänge closed
Women's health care	Gynecology unit in Avesta moved to Falun (69 km)
	Gynecology unit in Ludvika moved to Borlänge (43 km)
	Gynecology unit in Borlänge moved to Falun (20 km)
Medicine	Geriatric unit at Borlänge hospital closed
	Unit 70 and the stroke unit at Mora hospital merged
Primary care	Satellite health center in Nås closed/moved to Vansbro (26 km)
	Satellite health center in Furudal closed/moved to Rättvik (37 km)
	Satellite health center in Lima closed/moved to Sälen (26 km)
	Satellite health center in Fredriksberg closed/moved to Sunnansjö (39 km)
	Satellite health center in Söderbärke closed/moved to Smedjebacken (15 km)
	Satellite health center in Horndal closed/moved to Avesta (26 km)
	Satellite health center in Stora Skedvi closed/moved to Långshyttan (16 km)
	Grängesberg and Ludvika health centers merged
	Out of hours services at Falu hospital moved to health center Tisken
	Out of hours services at Borlänge hospital moved to health center Tisken in Falun (Monday-Thursdays 17:00-20:00) (20 km)
	Skogsgläntan rehabilitation center in Särna closed
	Training- and rehabilitation pools (primary care) closed
	The purchased medical resources in primary care are maximized to one doctor per three thousand "unlisted" patients.
Psychiatry	Adult open psychiatry unit in Hedemora closed, coordinated with Avesta and Falun
	Adult open psychiatry unit in Älvdalen closed, moved to Mora (140 km)
	Psychiatric unit in Leksand moved to Rättvik (21 km)
	Psychiatric unit in Vansbro moved to Malung (44 km)

	Adult psychiatry units in Rättvik and Malung reshaped into nurse-led satellite units with responsibility for Leksand and Vansbro
	Round-the-clock-care for patients with addictions coordinated to Falun
	Adult psychiatry councelling moved to psychiatric clinic in Borlänge
Recreation services	Recreation services in Tandådalen closed
Public health	Agreements with Dalarna municipalities regarding local public health functions will not be extended after the agreements expire.
Hospitals	Assignment to investigate the supply and level structuring of all hospitals in Dalarna

Table 3. Examples of activities in the Division of Surgery from the Annual Report 2016.

Review of	Indication thresholds within surgical units based on national comparisons
	The potential for reduce purchased care of highly specialised surgical care
	Efforts to reduce purchased care within the waiting-time guarantee and freedom of choice.
	Patient transport services
	Price list for the air ambulance service
	Price list for surgery and orthopaedics
Efficiency	"Task-shifting" to utilize personnel resources effectively based on available resources
	Arrival registration at electronic terminals for outpatient clinics
	Development of online appointment books to reduce the need for reception staff
	Ongoing optimization of surgical production
Investments	Acquisition of a four-patient ambulance to enhance the efficiency of patient transport to regional hospitals
	Hiring of a controller within the surgical clinic
Pharmaceutical therapies	Revised medication usage within ophthalmology
	Revised medication practices at the Paediatric and Adolescent Clinic in accordance with national guidelines

Healthcare Decommissioning Research: Contributions and Gaps

A number of researchers have made contributions to the advancement of knowledge in the field of healthcare decommissioning. Robert et al. have identified issues and processes informed by healthcare managers, that should be in focus to achieve high performance during decommissioning, including quality and patient safety, clinical effectiveness and cost-effectiveness. However, the gap between the rhetoric of the guiding principles and the reality of how decommissioning processes unfold in healthcare have revealed tensions. In practice, the main factors driving decommissioning are budgetary constraints, government intervention and capital expenditures (51). Williams et al. have made notable contributions and argue that there is a paucity of robust evidence and guidance to inform the design and implementation of decommissioning programmes. Although there is a very extensive literature on implementation of interventions in healthcare (see e.g. Nilsen et al. (71) and Grol et al. (72)) this literature often assumes that resources can be added or at least kept at the current level, while decommissioning requires implementation while trying to reduce resource use. Consequently, there is a pressing need to develop a more profound understanding of the intricacies and outcomes of decommissioning programmes, which is essential for the creation of evidence-based guidance to facilitate successful implementation. In particular, there is a need for more empirical, process-oriented research on the broader dimensions of decommissioning, as well as on specific programmes in a wider context (48, 49). Moreover, Harlock et al. posit that local healthcare systems may encounter challenges in successfully implementing decommissioning decisions unless pertinent issues such as engagement, local context, and outcomes are addressed. In addition, it remains unclear what 'success' means in relation to decommissioning processes, which emphasises the need for in-depth qualitative research into the relational and political dimensions of decommissioning (50). Consequently, there is a compelling need for empirical studies encompassing a more extensive scale of decommissioning. This thesis undertakes an examination of a large-scale decommissioning programme, employing a dual approach of quantitative and qualitative methods.

Rationale

To sustain healthcare service levels, significant budget improvements will be needed in the coming years. Consequently, decommissioning processes and programmes will likely become a routine part of healthcare systems. Research on decommissioning processes has found that the risk of falling short of its intention is more pronounced than in other forms of service change (48). It has been advised that an important step towards gaining a deeper understanding of how decommissioning programmes unfold in different types of healthcare systems and contexts will involve undertaking more and richer empirical studies (51). To reduce the risk of failing, wasting time, money and losing employees' trust, it is important to explore and learn from real case scenarios of successful decommissioning. Furthermore, there is currently limited knowledge regarding the experiences of individuals deeply involved in decommissioning processes (50), such as politicians, public servants and healthcare managers. Exploring the implementation of a decommissioning programme that achieved its intent in a local healthcare system could provide a deeper knowledge about the factors and processes perceived as important by politicians, public servants and healthcare managers. Another knowledge gap concerns priority setting frameworks during large-scale decommissioning programmes (73). Exploring how and when these frameworks support healthcare managers in making evidence-based decisions and enhancing legitimacy within clinics is essential.

Aim

The overall aim of this thesis is to contribute with empirical evidence on the factors healthcare leaders consider important when implementing a large-scale decommissioning programme within a local healthcare system.

This aim is achieved through four studies, of which the first aims to capture implementation experiences of clinic managers and the second experiences of politicians and public servants. The third study compares the perceptions of unit and department managers (the latter referred to as clinic managers in

study I), while the fourth one focuses on the department managers perceptions of a narrower aspect of the decommission programme, a priority-setting model.

Studies I-IV – aims, methods and results

The thesis is based on four empirical studies, the specific aims of these studies are presented in the following section. Table 4 summarizes the study designs, samples, data and analyses of studies I-IV. For more detailed descriptions, please see the attached articles and manuscript.

Aims

Study I

The aim was to investigate clinic managers' experiences of successfully implementing a decommissioning programme in a local healthcare organisation and what factors they considered as the most important enabling the decommissioning processes.

Study 2

The aim was to identify factors politicians and public servants consider most important for facilitating decommissioning processes to increase the ability to achieve the intent of decommissioning processes efficiently and successfully.

Study 3

The aim of the study was to describe and compare unit and department managers' perceptions concerning the implementation of a decommissioning programme in terms of the region's leadership, as well as their own participation, commitment, and responsibility.

Study 4

The aim of the study was to explore the department managers' perceptions of using the National Model for Transparent Prioritisation (NMTP) at their clinics. The study also investigated if, and how, the NMTP was perceived to contribute and bring about fair priorities, procedural and substantive legitimacy within the clinics.

Table 4. Overview of the study designs, samples, data and analyses

	Design	Sample	Data	Analysis
Study I	Qualitative interview design	Clinic (department) managers (n=26)	Semi structured interviews	Deductive content analysis
Study II	Qualitative interview design	Politicians (n=6) Public servants, non-clinical (n=8) Public servants, clinical (n=4)	Semi structured interviews	Deductive content analysis
Study III	Cross-sectional design	Department managers (n=50) Unit managers (n=112)	Survey data	Survey development, independent-samples t-test, Cohen's d, Mann–Whitney U test
Study IV	Convergent mixed method design	Department managers Survey (n=33) Interviews (n=22)	Survey data Semi structured interviews	Survey development Descriptive statistics

Methods

In this section, the methods of the two qualitative studies (I - II) are presented, followed by a quantitative study (III) and a mixed methods study (IV).

Studies I and II

Design

These studies applied a qualitative deductive design, with a focus on the experiences of clinic managers in Study I and on politicians and public servants in Study II.

Study setting Study I

The strategic selection of informants was made from all 50 clinic managers (referred to as department managers in studies III and IV) from the four divisions: psychiatry, primary care, surgery and medicine. The selection of clinic managers was based on their responsibility for patient care and decisions regarding treatment and medical interventions, and thus, costs linked to patient care. Consequently, service departments such as X-ray clinics and emergency departments were excluded from the study. Furthermore, it was a prerequisite for the clinic managers to have been in post in the region since 2016. In the context of primary care, informants were selected from diverse geographical areas within Region Dalarna. Twenty-six clinic managers participated in the interviews.

Study setting Study II

The selection of informants from the executive leadership team was made strategically, and covered individuals assigned to and playing a significant role in the development and implementation of the decommissioning programme. Eighteen individuals from the executive leadership team participated in the study, including politicians and public servants (non-clinical and clinical). Opposition politicians were among the informants (see Table 1).

Data collection

Semi-structured interview guides were designed to capture how clinic managers (Study I) and politicians and public servants (Study II) experienced the decommissioning programme and their participation in the implementation of the decommissioning programme. Interviews lasted 30–75 minutes for clinic managers and 45-60 minutes for politicians and public servants. All interviews were audiotaped with permission and conducted at the informants' workplaces.

Analysis

Deductive content analysis was used to analyse the interviews in both Study I and II (74, 75) with the analysis supported by a framework on factors and processes that shape the successful implementation of decommissioning decisions (51). The three factors and 30 underlying subcategories were used as the analytical framework in studies I and II.

The analysis was conducted in a series of steps. Initially, the interviews were transcribed verbatim, and the first and last author read the material repeatedly to gain an understanding of the complete interview content. The first author employed NVivo 11.0 to code relevant interview material into categories and subcategories that aligned with the factors in the framework. The coded material remained as quotes in the subcategories throughout the analysis procedure. The last author then read the subcategories and verified the findings to ensure reproducibility (76). A small number of interpretations differed, and the first and last authors re-read these sections and discussed to reach precision and consensus. Finally, all authors read and discussed the coding of three interviews to ensure dependability and confirmability.

In Study II, the interviews were re-examined by two authors to identify and discuss a frequent and specific theme that characterised the key factors. By identifying this common characteristic inductively, an important overarching theme of the facilitating key factors was found.

Studies III and IV

Design Studies III and IV

A survey was developed, and a content validity survey was conducted, in which 15 former department and unit managers assessed the relevance of items in the questionnaire developed by the authors. The survey comprised four subscales, each with six to eight items. Three of these subscales were utilised in Study III to measure department and unit managers' perceptions of 1) the region's leadership, 2) their own participation, and 3) their own commitment/responsibility during the implementation of the decommissioning programme. The fourth subscale was used in Study IV, exploring department manager perceptions of a priority-setting model being implemented during the decommissioning programme (the NMTP).

Study III is a cross-sectional study based on a survey of healthcare managers' (department and unit) perceptions of leadership, participation, commitment and responsibility during the implementation of a decommissioning programme.

Study IV is a convergent mixed methods design based on a survey and interviews exploring department managers perception, use and legitimacy of a priority-setting model.

Study setting studies III and IV

All department and unit managers in Region Dalarna being responsible for healthcare services related to patients were invited to participate in the survey in Study III. Department managers who had participated in education and training sessions and used the NMTP in their respective departments participated in Study IV.

Data collection Study III

The data collection was carried out through procedures adapted to meet each manager group's work situation and convenience. Fifty-four department managers were invited to participate in the survey during one of their bi-annual department managers' meetings. Four managers were not present at the meeting and did not participate in the study.

The unit managers received a web survey distributed through the region's e-mail system. A total of 211 unit managers were invited to participate, resulting in a total number of 122 responses.

Data collection Study IV

A section of the survey used in Study III comprised six items that focused on the utilisation and legitimacy of the NMTP priority-setting model. This section was exclusively completed by the department managers for Study IV. Study IV's convergent design incorporates interviews concerning the utilisation and legitimacy of the priority-setting model. These interviews were conducted concurrently with those conducted with department managers in Study I.

Analysis Study III

Subscale scores were compared between department and unit managers, using the independent-samples *t*-test. The effect size (Cohen's *d*), mean value, and confidence interval are presented for the subscales. In addition, the percent of maximum score is presented for each manager group and subscale, computed as the mean score divided by the subscale's maximum score. The comparison between department and unit manager for scores of individual items was analysed using the Mann–Whitney *U* test. To investigate whether potential within-group differences could be associated with the managers´ level of support, question 20 (Overall, I support how the executive leadership team handles priorities and resource allocation) was dichotomised into *disagree* (strongly disagree, disagree and neither) and *agree* (agree and strongly agree) and *t*-tests performed for the three subscales.

Analysis Study IV

The analysis in this convergent mixed method study involved several steps. Initially, a descriptive analysis of the quantitative data (the questionnaire) was conducted, complemented by a deductive content analysis of the qualitative data (the interviews), using the survey questions as a guide. Supporting quotes are provided to verify the qualitative analysis. The framework developed by Sibbald et al. (62) and the ten key elements crucial for successful priority setting serve as a knowledge base to add theory to the data-driven inferences (quantitative and qualitative data). Applicable elements from the knowledge base are applied to the joint display. Finally, the data-driven inferences are compared and assessed for confirmation and complementarity (77). By merging and incorporating the data-driven inferences and examining the fit with the knowledge base, a final meta inference for each question is decided. The analysis and inferences from these steps are presented in six joint displays. Joint displays are reported to be an effective way of integrating and presenting quantitative and qualitative analysis and findings in mixed methods (78).

Results

This section presents a concise overview of the results of studies I-IV.

Study I

Study I investigated clinic managers´ experiences of successfully implementing a decommissioning programme in a local healthcare organisation and the factors they considered as the most important enabling the decommissioning processes.

A key factor in facilitating the execution of the decommissioning programme was the presentation of the problem and the rationale for change in a credible manner, underpinned by compelling evidence. The novel approach of presenting the rationale through a scientifically grounded review report proved to be a convincing approach for the department managers. Securing political support for the profession's ability to take responsibility for both the process and outcome of the decommissioning programme was another crucial factor. An essential element in this regard was the early involvement of department managers and professionals in the decision-making processes. Department managers described this process as inclusive, knowledge-driven and professionally controlled. The presence of clinical champions within the executive leadership team was identified as a key factor in achieving organisational objectives and gaining legitimacy for the decommissioning programme. It is evident that department managers were required to exercise considerable emotional intelligence in order to successfully navigate the implementation of the decommissioning programme. Moreover, they had to be attentive to the necessity of fostering cultural and behavioural change in the organisation, and to demonstrate and communicate demonstrable benefits along the way.

Study II

Study II, explored the factors politicians and public servants consider most important for facilitating decommissioning processes to increase the ability to achieve the intent of decommissioning processes efficiently and successfully.

Seven crucial factors were described to be most important in facilitating the implementation of the decommissioning programme. First, at the start of the process, 1) a solid review-report contributed evidence that made 2) the rationale for change undeniable, and this strengthened 3) the political support for change. Second, strengthened leadership capability both in 4) executive and 5) clinical leadership teams, which were given the responsibility to lead

the decision-making and implementation of the decommissioning programme supported by 6) the quality of project management. Third, 7) a cultural and behavioural change among managers and employees, towards an acceptance for a more responsible use of resources, was considered the most valuable outcome and the path forward. Furthermore, trust was considered as an overarching attribute to all the seven key factors.

Study III

Study III described and compared unit and department managers' perceptions concerning the implementation of a decommissioning programme in terms of the region's leadership, as well as their own participation, commitment, and responsibility.

Department managers presented higher mean scores in all subscales (Leadership, Participation and Commitment), and they also seemed to be more satisfied with the process compared to unit managers. There was a significant difference between department and unit managers in their experiences of the region's leadership and their own participation in the decommissioning programme. Unit managers were more dissatisfied with the way it developed compared to department managers. For example, unit managers reported a lower level of leadership support and incentives to participate, and that their knowledge and skills were not fully utilised.

Study IV

Study IV, investigated how the National Model for Transparent Prioritisation [NMTP] was used in practice and the experience of department managers at clinics using the NMTP. The study also investigated if, and how, the NMTP was perceived to contribute and bring about fair priorities, procedural and substantive legitimacy within the clinics.

The majority of department managers perceived that the NMTP contributed to high-quality decision-making and transparency, as well as to prioritising patients with the greatest need. However, the findings indicate that the utilisation of the NMTP model was weak in more than half of the departments, meaning that the aim of introducing the NMTP, i.e. to bring consistency to the decision-making process, was not fully achieved. Despite this, approximately half of the respondents considered the time and resources required to be justified and believed that the model ensured that patients with the greatest need were given the highest priority. The reasons why the NMTP was not used

more widely varied, including time constraints and a high initial threshold. Regarding the legitimacy of the NMTP, there was a divergence in acceptance across departments, with the majority being somewhat reluctant to adopt it.

Discussion

The overall aim of this thesis is to contribute with empirical evidence on the factors healthcare managers consider important when implementing a large-scale decommissioning programme within a local healthcare organisation.

There are several reasons why this research is important. The four empirical studies contribute with a deeper understanding and illuminate circumstances that are challenging, because the desirable decommissioning activities are a response to resource scarcity. This type of implementation is considered extra difficult and is often resisted by healthcare managers, patients as well as the public (47, 51, 54). In the case described in the thesis, overall implementation can be considered successful, and the studies illustrate how decisions were made, what challenges were encountered, and which factors were prioritized as being crucial by those in leadership roles. The results can help developing better change management strategies, causing less disruption within healthcare organizations in situations where more drastic measures have to be taken to make the healthcare system more sustainable and resilient. This is important because decommissioning can have wide-reaching impacts on patients, staff, and system performance. As healthcare systems worldwide are put under increasing pressure, insights into effective decommissioning can contribute to improved sustainability and resilience. Previous empirical studies of decommissioning have often investigated smaller initiatives than the case in this thesis, mostly within the United Kingdom (48, 49). The contribution from this thesis include rich empirical illustrations about the content, attributes, and characteristics of factors of importance for implementation, creating a deeper understanding of politicians and public servants' myriads of challenges when facing, deciding, and introducing the necessity of decommissioning in a healthcare system.

Decommissioning introduces political risks, that is risks of not being re-elected, particularly in a context where there is a strong societal value placed on universal healthcare services of high quality. The uncertainty surrounding the outcomes of decommissioning programmes, especially regarding their impact on equity, exacerbates these risks (50). Decommissioning processes are

not always as straightforward as the case studied in this thesis. Williams et al. describe political vulnerability as a possible predictor of whether decommissioning decisions will be implemented as intended. Institutions with strong stakeholders, who sometimes act out of self-interest, could undermine proposed decommissioning decisions and prove resilient to change. In other cases, organizations may be more vulnerable and have less capacity to resist proposed changes, influenced by factors such as size, leadership, or other dependencies (49). It is important to acknowledge the potential conflict of interest that could emerge when clinical leaders turn into competitors with other departments within their own organisation. A scenario that could lead to obstruction of innovation and change, and be counterproductive (79), is when leaders are more concerned with how to survive than characterized by confidence and strategic leadership (80). Region Dalarna had long been unable to deliver care within the designated budget. The economy had declined significantly, necessitating the region to borrow money to pay salaries. The region was in a vulnerable situation where politicians and public servants were pressured to handle the escalating negative financial situation. The executive leadership was compelled to act and decided to change their approach compared to earlier attempts to balance the economy. Rather than implementing a uniform percentage reduction (cheese slicing), the executive leadership team decided to involve and collaborate with healthcare managers from the beginning to determine the best approach to handle the critical situation. Moreover, in order to address the escalating financial situation, the issue was conceptualised as a collective challenge. This approach was adopted to prevent the identification of scapegoats and to foster a collaborative environment, thereby avoiding a competitive atmosphere. The division managers (four public servants with a clinical background) led the newly established divisions (primary care, surgery, medicine and psychiatry) and successfully established trust and legitimacy among the department managers to engage and be loyal to the hard work of carrying through the changes. In other scenarios, researchers imply that executive leadership teams struggle to balance financial priorities with the collaboration needed to address quality of patient care, professionals' engagement, and economic efficiency. Despite acknowledging the importance of this balance, the pressures they face often push them to prioritize economic concerns, detracting from broader healthcare objectives (81).

As the results in the thesis show, an initial persuasive narrative substantiated by evidence was a necessary factor for aligning all stakeholders and gaining the support of department managers for the decommissioning program. Furthermore, it was essential to secure political support for the healthcare

profession's ability to take responsibility for both the process and outcome of the decommissioning programme. These are findings that correspond well with results from previous studies that clarify that a strong leadership team, political support and clinical leaders' involvement are important factors to consider in decommissioning processes (46, 49, 82). Moreover, a way to create the important factor, a strong executive leadership team, may unexpectedly look like a partnership, sharing demands, blame and success, deeply grounded in trusting each other's proficiency and abilities (14).

It is evident that a number of specific conditions contributed to the successful outcome. Firstly, there was a clear crisis awareness that had been developed over a period of years of economic challenges. This, in turn, served to underscore the rationale for change, the necessity for radical changes. Secondly, there were long-standing relationships within a relatively small group of politicians and public servants. In addition, the presence of clinical champions was identified as a key factor of a robust executive leadership team. These champions were found to be invaluable in fostering trust and legitimacy in the processes, ensuring that the organisation's strategic objectives were successfully achieved (83, 84).

Scholars report that it is important to frame the intentions of decommissioning decisions in a credible way (14, 85, 86). The executive leadership team successfully outlined the rationale and necessity for the decommissioning programme. The scientific approach used to present this information effectively resonated with healthcare professionals, fostering a strong sense of commitment to the programme's intentions. Another factor highlighted by politicians and public servants was the need to secure a set of crucial factors at specific parts of the decommissioning programme. For example, at the beginning of the process: a clear rationale, stable evidence and political support, and at the end of the implementation process: the path forward, as well as strategies to preserve the cultural and behavioural changes from the change process to achieve sustainability. Moreover, the transparent evaluation and visualisation of the departments' contribution to resolving the region's economic challenges were found to be of crucial importance for fostering commitment and fairness during the processes.

Results from the survey reveals significant differences in experiences between department and unit managers involved in the large-scale decommissioning programme. While both groups supported the executive leadership's approach, department managers reported higher level of satisfaction and confidence in the executive leadership team. Unit managers were more dissatisfied with how

the decommissioning programme unfolded. For example, they felt underutilized and lacked opportunities to challenge decisions. The findings of the present study suggest that an increased level of involvement from unit managers might result in enhanced outcomes for decommissioning programmes. Previous research has shown that clear communication of changes, particularly regarding economic challenges, can enhance understanding and cooperation among healthcare managers (87-90). Meanwhile, department managers play a crucial role as change implementers and need to effectively communicate the rationale behind decommissioning to their staff (19, 24) and their unit managers.

Furthermore, the department managers had to handle strong emotions such as disappointment and anger at some departments during the implementation of the decommissioning programme. To handle the reactions, the managers found support in each other, in the divisions and in a new leadership program. At the same time, several department managers reported that the change process had facilitated both their own and their staff's professional and personal development. This result is supported by research that explain that providing emotional support to staff during changes fosters learning for individuals and groups (91).

Although the decommissioning programme was overall successful and most of the programme activities were implemented, the thesis shows that the department managers had diverse perceptions of the National Model for Transparent Prioritisation (NMTP) and had implemented it to a varying degree. However, the relatively low level of acceptance is surprising given that most of the department managers generally perceived that the NMTP contributed to better and more equitable priorities, and that the time and resources expended in using the NMTP were justified. The results of the study emphasise the importance of thorough planning and clear introduction of priority-setting models within broader resource allocation projects, such as large-scale decommissioning programmes, to ensure compliance and alignment with local, regional, and national goals. The utilisation of priority-setting models is an intense process that requires a significant investment of time and knowledge, as well as the acceptance of the model by stakeholders as a way of achieving fair priorities and equitable health policy.

It is important to note that the studies within this thesis do not cover aspects such as patients experiences and social consequences. It does not cover effect studies or analyses of how specific patient groups or local areas have been

affected by the changes in the decommissioning programme. Overall, it is difficult to link measures such as health outcomes or productivity to specific interventions.

In 2023, Region Dalarna again projected a significant budget deficit, underscoring the ongoing need for effective resource management and the potential for regular decommissioning programmes in the future. This evolving landscape necessitates careful long-term planning and the inclusion of managers at all levels to navigate the complexities of healthcare resource allocation, reforms, emerging technologies, and shifting political priorities. In Sweden, all goals are prioritised concurrently, which carries the risk of crowding out core elements such as ethics, equity and patient safety. Enhancing knowledge and clarifying national and regional structures and mandates have the potential to alleviate stress and improve system efficacy in the face of ongoing challenges in the healthcare sector.

Conclusions

This thesis presents results from four different studies exploring leadership perceptions on factors being essential for the successful implementation of a large-scale decommissioning programme in a local healthcare system. Through the studies, several critical factors and different perspectives were identified, which could be used by other leaders with responsibility for local healthcare systems as well: for example, creating a compelling narrative to align stakeholders, securing strong executive and clinical leadership, engaging clinic managers early in the process, and making decisions based on evidence. Additionally, it was found that involving public servants with a clinical background in executive leadership roles enhanced trust and legitimacy in the decommissioning process. Furthermore, the importance of transparent communication, addressing cultural and behavioural changes, and evaluating the outcomes of the decommissioning processes were emphasised. The studies also reveal differences in the experiences of department and unit managers, with unit managers reporting lower levels of support and involvement. This suggests that more inclusive engagement of unit managers could improve decommissioning outcomes.

Practical implications

The findings of this empirical research suggest that a number of important factors should be considered to enhance the likelihood of success for decommissioning programmes.

Framing is essential – it is crucial to have a credible and influential individual who can communicate a compelling, evidence-based narrative that clearly explains the rationale and necessity of decommissioning.

Skilled leadership – navigating decommissioning in healthcare requires leaders who can balance changes with consideration, ensuring that the needs of both patients and healthcare professionals are met while striving for a more sustainable and effective healthcare system.

Presence of clinical champions – an executive leadership team comprising clinical champions contributes with legitimacy, competence and trust in the decommissioning programme.

Communicate the benefits – decommissioning is often an opportunity to improve, modernize and embrace new technologies. Staff engagement is particularly important in the redesign of services and tasks. This can help mitigate feelings of uncertainty or loss.

Involve unit managers – because decommissioning processes have a significant risk of failure compared to other change processes in healthcare, the involvement of unit managers, in a more fruitful way, could improve outcomes and achieve the intentions of decommissioning decisions.

In-house project management – avoid external consultants to keep experience, learning and knowledge within the organisation.

Methodological considerations

The following sections provide a rationale for the selection of methods employed in Studies I-IV.

Study I and II

The structure for the analysis in a deductive content analysis is operationalized based on previous knowledge or theory (in the present case, factors and

processes that facilitate the successful implementation of decisions to decommission healthcare services). In contrast, in inductive content analysis, concepts are derived from the data itself. Inductive content analysis is typically used when there are no prior studies on the phenomenon or when existing knowledge is scattered. Conversely, a deductive approach is particularly advantageous when the objective is to test a prior theory in a different context, to make comparisons over time, or when existing theory or prior research about a phenomenon exists, but the phenomenon would benefit from further description (92, 93).

The use of a framework helped organize and analyze the data in studies I and II. As the framework consists of aggregated knowledge condensed by expert propositions, we felt secure not to miss any hidden success factors already known to facilitate decommissioning decisions (51). An inductive approach would not have provided a more comprehensive understanding of the real-life success factors associated with decommissioning. It was evident that several factors were addressed in all interviews with healthcare managers, revisiting these issues on multiple occasions during the interviews. The content of these interviews was largely focused on the significant factors reported in Studies I and II. However, it should be acknowledged that the analysis was open to novel findings, as illustrated by the overarching theme of trust in Study II, which was inductively developed in the interviews (75).

In a content analysis, trustworthiness should continue through the whole process, starting by carefully selecting participants that have experience and something to share about the 'phenomenon' that is in focus. By recruiting healthcare leaders who were responsible for both the process and outcome of decommissioning decisions as well as politicians and public servants who initiated and decided to implement the decommissioning programme, the selection of respondents met these requirements (94). The 44 interviews were very rich in content, with participants representing different healthcare clinics, political party leaders and public servants with a variety of assignments, all deeply involved in different phases of the implementation of the decommissioning programme. Dependability is another challenge that we tried to handle, by being two or more researchers performing the interpretation and analysis of the interview data. To give participants a voice and allow readers to assess credibility and authenticity, numerous quotes are presented in the results section of study I and II (94).

Studies III and IV

In order to assess healthcare managers' perceptions regarding the region's leadership, their own participation and engagement in Study III, a questionnaire was developed, as no suitable instruments were available for use. The questionnaire also included items to measure department managers' perceptions of the priority-setting model introduced during the decommissioning programme, which provided the quantitative component of the mixed methods study (IV). The development of the instrument was an extensive process, incorporating various techniques to ensure the validity of the questions and subscales. These techniques included the calculation of I-CVI, S-CVI, and Cronbach's alpha. During the development of the survey, 15 former healthcare managers were invited to assess the relevance of the questions through a content validity survey. Participants were selected using the snowball sampling method and provided feedback on the relevance and clarity of the items. This feedback led to the deletion and rephrasing of several items.

Lickert scales are widely used in survey research to measure attitudes, opinions, and perceptions. However, they do come with certain challenges and problems. Likert scales are treated as interval data, but technically, the data they produced through is ordinal. Likert scales condense complex opinions and feelings into a limited number of categories. This simplification can obscure the richness of respondents' views, leading to a loss of nuanced information about their attitudes (95). In study IV this problem is addressed by employing a mixed methods design that incorporates qualitative data.

Generalisability

The findings identifying facilitating factors for successful decommissioning can be generalised to other healthcare systems. While context, strategies, and healthcare systems may differ, nearly all identified factors – such as culture and emotional resistance to change, including fear of insecurity and uncertainty – are universal. It is imperative for healthcare leaders to incorporate this understanding of human nature into their change strategies, acknowledging that effective implementation of any program, including decommissioning, necessitates cultural sensitivity and emotional intelligence.

Strengths and Limitations of the studies

The response rate of the surveys is a notable strength of the thesis. Web-based surveys generally have lower average response rate than those administered via other modes, such as paper-based surveys. A meta-analysis of 1071 online

surveys included in articles found the average response rate to be 44,1 % (96). While there is no established standard for comparison, the 93 % response rate for department managers and 58% for unit mangers appears to be sufficient.

The extended time period (2-3 years) between the decommissioning programme started and the interviews were conducted could be a weakness, even if the implementation process was still ongoing at the time of the data collection. This is due to the possibility that the informants may encounter difficulties in recalling past events. While the time lag could introduce recall bias, it could also have allowed the informants to discuss the process based on their own processing and reflections.

Ethical considerations

Approval from the ethical board was obtained for the interviews in studies I-III (Dnr. 2016/504) and for the surveys in studies III-IV (Dnr. 2016/504-1B). Studies I and II have been reported with the guidance of e.g., Consolidated criteria for reporting qualitative research (COREQ) (97). The survey Study III, has been reported in accordance to STROBE Statement – checklist of cross-sectional studies (98).

Good research ethics extend beyond rules and guidelines and the approvals that are initially required to start research projects. During different phases of the research process, ethical dilemmas arose that could not have been foreseen when planning the studies. Some dilemmas required reflections and discussion with the supervisor group on how to best address these issues. In Study I, the interviewed healthcare leaders were offered to read transcripts of their interview, and some accepted, but most felt they did not need to read it. In two cases, the interviewees were contacted and advised to read their statements. These decisions were made because the authors assessed the quotes to be very personal and strong and wanted to make sure that the interviewees still agreed that their statements could be included in the article.

In Study III and IV, to ensure anonymity for the respondents who participated in the survey, the authors decided to report the results without presenting gender and age.

Avenues for future research

Research exploring patients' perceptions, experiences, and the consequences of health service decommissioning is essential. This includes understanding

how patients are affected in terms of access to care, quality of services, and emotional impact. A deeper understanding of the social and ethical implications of decommissioning in healthcare services is needed.

Another important issue is examining how decommissioning affects the work environment for healthcare staff, including their attitudes and workload.

Unit managers' perceptions of leadership and their opportunities to participate in decision-making processes may benefit from deeper insights, such as interviews, to better understand their roles in decommissioning processes and leverage their specific skills and competencies.

Research should focus on how digitalization and new technologies can be used before, during, and after decommissioning processes to enhance practice. Overall, establishing a robust research agenda to continuously evaluate and improve decommissioning processes and their effects on the healthcare system, patients, and personnel is essential.

Sammanfattning på svenska

Avhandlingen utgår från det struktur- och förändringsarbete inom hälso- och sjukvården som inleddes 2015, då Region Dalarna stod inför en svår ekonomisk situation med ett sparkrav på 700 Mkr.

Hälso- och sjukvårdssystem världen över står inför utmaningen att möta ökande behov med begränsade resurser. Den medicinska utvecklingen är positiv men också kostnadsdrivande. I många länder ökar den s.k. försörjningskvoten, vilket innebär att allt färre individer i arbetsför ålder ska försörja en växande äldre befolkning med omfattande vårdbehov. Frågor om hälso- och sjukvårdens ekonomiska situation är ständigt aktuella, och hur omställningar och anpassningar av vården ska beslutas, utformas och implementeras för att bidra till en patientsäker, tillgänglig och kostnadseffektiv vård kommer vara avgörande under lång tid.

Struktur- och förändringsarbete inom hälso- och sjukvård, som i Region Dalarna 2015–2019, innebär ofta omställningar som kan påverka vårdtillgång, möten mellan patient och vårdpersonal, servicenivåer och gällande indikationsgränser. Kunskapen om hur sådana omställningar sker och under vilka förhållanden är begränsad. Empiriska studier om chefers förutsättningar att hantera de ofta emotionellt laddade förändringsprocesserna initierade av ekonomiska åtstramningar är sällsynta och kunskapsluckorna stora. Frågor om hur sjukvårdens begränsade resurser bäst ska användas för att möta befolkningens ökande behov kräver kunskap, strategier och chefer som klarar att genomföra förändringarna med värdighet och resultat som accepteras av berörda grupper.

Forskning om förändring- och omställningsprocesser, initierade av ekonomiska åtstramningar (s.k. decommissioning), inom hälso- och sjukvården har visat att risken för att inte nå avsedda mål är större än vid andra former förändringsprocesser. Det har föreslagits att ett viktigt steg mot en djupare förståelse för hur sådana omställningsprocesser sker i olika typer av sjukvårdssystem och sammanhang är att genomföra fler empiriska studier. Att studera implementeringen av ett lyckat omställningsprogram i ett lokalt hälso- och

sjukvårdssystem som uppnått sitt mål ger en djupare insikt om de faktorer och processer som politiker, tjänstemän och vårdchefer rapporterar som viktiga i sammanhanget.

Chefer inom den patientnära vården, verksamhetschefer och avdelningschefer, är nyckelpersoner med stort ansvar att hantera gapet mellan vårdbehov och tillgängliga resurser, samtidigt som etiska principer och värden som vägleder svensk hälso- och sjukvård ska respekteras. Med ökad kunskap om vad som stärker, underlättar och bidrar till kvalitet i omställningsprocesser kan optimala förutsättningar skapas, vilket ökar möjligheten att resurser fördelas rättvist och klokt till de patientgrupper som har störst behov, nu och i framtiden. Kunskap om den högsta ledningens och de patientnära chefernas uppfattningar av det struktur- och förändringsarbete som utfördes i Region Dalarna 2015–2019 är en viktig nyckel för framtida optimering av beslutsfattande och implementering, så att viktiga värden och underlättande faktorer beaktas och synliggörs.

Syftet med avhandlingen var att undersöka vilka faktorer politiker, tjänstemän och hälso- och sjukvårdschefer (verksamhetschefer och avdelningschefer) ansåg vara viktiga i arbetet med struktur- och förändringsarbetet.

I avhandlingen identifierades många faktorer som ansågs vara avgörande. En mycket viktig faktor som möjliggjorde struktur- och förändringsarbetet var att skälen till förändringarna ramades in och presenterades på ett trovärdigt sätt med hjälp av en granskningsrapport som presenterade regionens problematiska situation. Att presentera motiven för förändring genom en vetenskapligt baserad granskningsrapport tilltalade verksamhetscheferna. Vidare var en viktig faktor att tidigt involvera verksamhetscheferna för att identifiera förändringsförslag. Verksamhetscheferna beskrev processen som inkluderande, kunskapsdriven och professionellt kontrollerad. För att säkerställa organisationens övergripande mål och få legitimitet för struktur- och förändringsarbetet var närvaron av divisionschefer i den verkställande ledningsgruppen ovärderlig. Att säkra politiskt stöd för professionens ansvarstagande för både process och utfall av struktur- och förändringsarbetet var en annan avgörande faktor.

Verksamhetscheferna behövde hantera starka känslor och spänningar under genomförandet av struktur- och förändringsarbetet, uppmärksamma nödvändigheten av en kulturell och beteendemässig förändring inom organisationen samt kommunicera och presentera påvisbara fördelar längs vägen. Vidare studerades avdelningschefer och verksamhetschefers uppfattningar om regionens

ledarskap i omställningsarbetet, deras egen delaktighet och engagemang för att säkerställa en rättvis och evidensbaserad vård. Resultaten visar behovet av att stärka regionens förmåga att planera, optimera och skapa större delaktighet i de processer som pågår under ett omfattande struktur- och förändringsarbete och att avdelningschefernas kompetens och erfarenhet i högre grad kan tillvaratas. Majoriteten av verksamhetscheferna ansåg att den Nationella modellen för öppna prioriteringar som implementerades som en del i struktur- och förändringsarbetet förbättrade beslutskvalitet, transparens och prioritering av patienter med störst behov. Emellertid bidrog olika faktorer, såsom tidsbegränsningar och en hög initial tröskel, till modellens begränsade acceptans och användning.

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