Introduction

Like many other European countries, Denmark has also had challenges in promoting integration in health care. The Danish health care system is well organised in both its primary health care (general practitioners and municipalities) and secondary health care (hospitals) sectors. However, the relation between the two sectors often lacks coordination and other mediating structures. The latest and most comprehensive reform of Danish local administration, the ‘structural reform’ from (2007) has tried to address these grey zones, silo-style-thinking and unclear division of responsibility. In the meantime, the reform can hardly be labeled a resounding success in terms of improving integration in the Danish health system. It has turned out that integration and coordination problems in health care cannot be solved simply by administrative restructuring.

Hence, the patient pathways through the Danish health care system can sometimes still be problematic. This is no surprise. Health care systems are in general notorious for their fragmentation, silo perspectives and silo solutions. For decades, cross-sector cooperation and integration in health care systems has been plagued by disagreements and conflicts over jurisdiction, technology, culture and professional boundaries. Denmark is no exception.

Focusing on cooperation and integration within and across the primary and secondary health care sector in Denmark reveals the diversity of strategies pursued by the various actors. Even when there is agreement among the relevant actors that integration and linkages are needed, different ideologies and philosophies generate considerable tension concerning modes of collaboration (Seemann & Antoft 2002; Seemann 2010; Seemann, Dinesen & Gustafsson 2013; Holm-Petersen & Sandberg 2014).

Developed cultures of individual norms and values are attached to health professional identities, local domains of work, and to common interests and destinies. Solidarity often ceases to exist at the boundaries of a group or an organisation, as each of the divisions develops its particular perception horizons and obligations. It inhibits the ability to think in an integrated fashion and to understand and interpret information in the most effective way. The health care sector faces an increasing demand for efficiency and integration of care, treatment and rehabilitation.

The aim of the paper is to take a look back into Danish history to learn some important lessons from integrative efforts through two major administrative reforms, in 1970 and in 2007. Other selected
initiatives in the 1980s and 1990s are also discussed. Our historical investigation reveals that there seems to have been chronic integration difficulties in Danish health care. We seem to have been addressing the same kind of integration-problems from 1970 up to the present. The paper addresses the causes of these chronic integration difficulties.

There are no simple explanations for these recurring integration difficulties. However, the inter-organisational management literature offers a useful focus on e.g. cooperative strategies, building of trust and more coherent organisational interfaces in health (Brown, 1983; Gustafsson 2007; Holm-Petersen & Sandberg 2014). Therefore, the paper concludes with some recommendations for how integration in health care could be achieved through inter-organisational management.

**The present health care system in Denmark**

The Danish health care system is a public system and is financed predominantly through general taxation. Denmark is divided into three administrative/political levels: the state, five regions and 98 municipalities. The state is taking care of overall financing and regulation. Both regions and municipalities are governed by directly elected politicians. The hospitals are owned and administered by the five existing regions but are financed by the state and the 98 different municipalities. Since 2007 (when a major structural reform was implemented), the regional authority can no longer collect tax revenues. The structural reform from 2007 will be uddybet nedenfor.

The approximately 3500 Danish general practitioners can be characterized as a liberal profession, who are remunerated according to performance and via a service contract with the regions. They act as gatekeepers to specialist hospital care. Since 2007, they have been financed by the state and municipalities, but they are still administered by the regions.

Historically, the Danish municipalities have financed and administered home care, nursing homes and child dental care – and they still do. After 2007, new health tasks have emerged whereby the municipality assumes full responsibility for preventive measures, health promotion and rehabilitation. The municipalities also have to pay 20% of hospitalization costs.

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The Danish health system has, with its regional center of gravity the potential to provide integrated care, but cultural, structural and managerial challenges have as a consequence, at …, the effort falls short and there are concerns regarding the coordination of service provision within and across hospitals, general practitioners and municipal services ((Rudkøbing et al., 2014).

The present study aims to try to understand why Denmark - despite representing one of the Scandinavian welfare models, known for a free service, a long tradition of cooperation within and between health and social care and a stated main goal of coordinated health care system in the Danish Health Act - is still struggling with the same problems of cooperation and integration since the 1970s.

The strenuous cooperation

Both the current and future coordination in the Danish health sector is a complex issue.

And the more one tries to understand the Danish health system as an organisational sociologist, the more complicated it becomes.

When we consider the Danish health system as a whole, we are talking about much more than a single administrative unit. It is also characteristic that there exists no clear, unambiguous definition of the health sector with the kind of fixed, shared values and goals that might ensure cross-cutting integration of the system’s multifaceted activities.

A major challenge consists of establishing mutual understandings between professions, sectors and political levels. It is assumed that communicative processes – and the desired effective and coherent solutions – are most successful when the involved actors have common goals, similar competencies and shared values, and where the agenda is clear (Oddvar Eriksen, 1993).

Seen from this perspective, it is not surprising that the many actors in the health sector can have considerable difficulties in achieving constructive, cross-cutting interaction. The health sector can be characterized by its great differences in the various actors’ views of reality, their interests, competencies and values. In addition, the agenda can also be especially complicated.

The health sector, therefore, faces a great need for communicative processes, while also having to face the difficulties of having to develop and apply these processes.

Many international studies of cross-cooperation in health care, including those conducted in Denmark, have shown the difficulties of cooperation. The studies have revealed a multitude of differing cultures and separate functions that obstruct communication and collaboration (Alter & Hage 1993; Millward & Provan 1996; Denise & Lamothe 1999; Grone & Garcia-Barbero 2001; Kodner & Spreuwenberg 2002; Mur –Veeman, van Raak & Paulus 2008; Wadman, Strandberg-Larsen & Vrangbaek 2009; Dinesen, Seemann & Gustafsson 2011; Axelsson et al., 2014; Holm Petersen & Sandberg 2014; Seemann & Gustafsson et al., 2015).
In the opinion of many experts, Denmark has created one of the world’s most advanced and developed welfare states. But with such high expectations and a lively public debate culture, Danes are made acutely aware of the limits of the welfare state model, where the dysfunctions take the form of complexity, opacity, silo barriers, and poor performance.

It has become increasingly difficult for the individual public organisation, the individual sector and the political levels to meet these challenges alone. We see this everywhere, for example, in connection with patient care, health prevention, care of the elderly, mental health treatment and in the development of complex IT systems and welfare technologies.

Without coherence in solving problems, we see narrow-minded thinking, domain conflicts, negative coordination and cooperation regarding the lowest common denominator, resulting in fragmented problem-solving, tasks left unresolved and poor resource utilization.

**Four developments challenging integration in health care**

Four trends will make integration within the health care sector an even more important challenge in the years to come:

*The ageing population*

Danes live longer. The growing number of old people who often suffer from complex or multi-chronic diseases will increase the need for cross-cutting coordination among hospitals, general practitioners and municipalities. The need for more an integrated health care system is especially important for people with (multi)chronic diseases, as these patients are especially vulnerable to fragmentation in health care systems.

*The increase of ‘multi-chronics’*

At present it is estimated that 1.7 million Danes out of a little more than 5.5 million Danish people suffer from chronic diseases (particularly, chronic obstructive pulmonary disease, diabetes, asthma, various heart diseases, mental disorders). More than half of them suffer from more than one chronic disease and approximately 75% of the Danish psychiatric patients have other chronic diseases. Approximately 16% of Danish psychiatric patients suffer from four or more physical diseases (Breinholt Larsen, 2008).

*‘Accelerated’ forms of treatment*

The hospitals’ use of accelerated forms of treatment, while having reduced the number of in-patients, has led to an increase in out-patient care. This development will continue, thereby increasing the need for coordination and cooperation of treatment, care and rehabilitation of out-patients or patients discharged from hospital.
The increase of patient demands

Today we have more patients who are better informed than ever before. They obtain information via the internet, and patients today and in the future will expect more individual and integrated treatment.

Integrative efforts and experiences since 1970 – but chronic integration difficulties

The Danish ‘collaboration agenda’ in health care, proclaimed by the central authorities from as early as the plans and reforms of 1970, remains largely the same. After more than four decades, the debate can thus be characterized as having a very high degree of ‘continuity’. The centrally announced Collaboration Agenda through 45 years (1970-2015) can be defined as follows:

- (continued) reinforced effort in the primary sector
- increased preventive effort
- clear and unambiguous allocation of tasks
- improved coordination and collaboration between the primary and secondary sectors
- improved knowledge and decision-making basis (cross-sector interventions)
- more ‘best practice’ examples (at present named ‘next practice’)


The history tells us that there seems to be chronic integration difficulties in Danish health care. In short, it means that we have addressed the same kind of integration-problems from 1970 up to the present.

In the following sections, we describe the two major administrative reforms that were implemented in Denmark in 1970 and in 2007. We also review additional initiatives, implemented through the 1980s, 1990s and 2000s, that focused on a more integrated healthcare system.

The Structural Reform of 1970

The administrative reform of 1970 was the most comprehensive reform of the Danish local government, reducing the number of municipalities from 1,098 to 277 and the number of counties from 25 to 14 (Pallesen, 2003). This structure remained largely unchanged until the second major reform in 2007, except for a further reduction in the number of municipalities to 273. At the same time, the 1970s saw the beginning of a centrally initiated discussion about the unified health system. The so-called Perspective Plans I and II (1970; 1973) signaled a greater emphasis on prevention, the strengthening of the primary sector (GPs) and a slowing down in the expansion of hospitals. The 1970s can be characterized by a generally growing criticism of the highly specialized Danish hospital model. In both the political and the public debate, it was argued that the strong specialization impaired doctors' ability to see patients as a whole, that it was difficult to set boundaries between the medical specialties, and that certain diseases did not fit into the
specialization's strong division of diseases and body parts (Vallgårda, 1992). This type of debate and criticism has continued up until today. This does not mean that there have not been numerous initiatives, breakthroughs and innovative solutions that strengthen the integration in the health care sector. However, in general, there remains a lack of integration across the many segments of the healthcare system.

‘Coordination Report’ 1985
The same barriers and problems in the coordination of the health system which were identified 30 years ago by the Coordination Report (Indenrigsministeriet,1985) remain with us today (Indenrigs- og Sundhedsministeriet 2004; KL et al. 2009).

Some of the essential problems and barriers mentioned in the Coordination Report included:

- Formal and structural political-administrative barriers budgeted and administered by different authorities, each with their own set of rules which result in inconvenient divisions.
- Group contract barriers with a complicated and divided system of agreement and with the right to negotiate and allocations allocate tasks on a variety of organisations and authorities which rarely share common interests as their point of departure.
- Conceptions and traditions related cultural barriers between professions as well as politicians and administrators, all of which impedes collaboration.
- Too few incentives to collaborate.

The ‘Toftegaard Committee Report’ 1987
The Toftegaard Committee (Socialstyrelsen, 1988) concluded that myths and lack of managerial initiative are the primary obstacles to a proper collaboration between the parties. Some of the most predominant myths were the following:

- The myth that collaboration is hindered because it is the hospital doctors’ who decide when treatment of an admitted patient has been completed.
- The myth that it is possible to generally determine what is a hospital task and what is a municipal task. This myth gives rise to controversies and mutual accusations between hospitals and municipalities.
- The myth that social welfare departments in the municipalities think of their work only in terms of legal provisions.
- The myth that physicians do not consider financial factors in their treatment activities.
- The myth that general practitioners do not have time (or motivation) to participate in any collaboration.
- The myth that hospital doctors are perfectionists without the necessary general experience with the patients.

The report suggested that these myths become ‘easy explanations’ used as excuses for not collaborating. The report also pointed out that the ‘easy explanations’ were used far beyond the concrete experiences and situations from which they originated (Socialstyrelsen 1988). At present
these myths continue to pervade, and at times dominate, the Danish health care (Seemann in Timm (ed.), 2010).

**Health Planning System introduced in 1994**

Since 1994, a formal health planning system has been established in order to facilitate more effective integration between the Danish regions and the municipalities in carrying out their health care tasks. A main part of this integration was the mandatory development of a health plan. The health plan should cover all preventive and curative activities and also include associated sectors like the social care sector. It was expected that the plans should be submitted to the National Board of Health for comment. The integrative health plans have been criticized as mere ‘rhetoric’ and for constructing barriers to achieving the aims of the planning system (Mooney, 2002; Seemann, 2003a, 2003b; Strandberg-Larsen et al., 2007). For example, it has been observed that health plans have attained the status as an institutional duty assignment, with limited impact at the operational level (Strandberg-Larsen et al., 2007:7).

In the meantime, the planning system was changed in line with the 2007 administrative reform. It was found that the new planning system was somewhat more useful than the system dating back to 1994. It was concluded that the new health planning system, with its formalized agreements, more specific content and regular follow-up mechanisms could be a useful tool for more integration of health and social services between regional and local levels (Rudkjøbing et al., 2014).

**The Structural Reform of 2007**

The reform of 2007 led to changes in the Danish health care system. A central aim of the reform was to improve the conditions for integrated patient flows. The number of regional authorities was reduced from 14 counties to 5 regions. The 273 municipalities were merged into 98.

In the Danish political debate, the 2007 Structural Reform has been claimed to be a radical change of the health system. However, it did not cause any sort of revolution in the Danish health system.

Rather, the reform led to a minor transfer of health tasks from regional to local level but with a significant restructuring of financing of the health system, especially as concerns municipal co-financing.

The main point of departure, however, was to increase the effectiveness of the hospitals with a focus on planning the specialized hospital units, and a consolidation or centralization of emergency hospital functions.

This meant an emphasis on structural rationalizations with a focus on the benefits of economies of scale and specialization, and the benefits of financial incentives (for example, more payment control and municipal co-financing in connection with hospitalizations).

Grey zones, silo-style thinking and unclear division of responsibility were the main motivations for the enactment of the 2007 Structural Reform and its project of altering the division of tasks between
state, regions and municipalities. With the redrawing of boundaries in the Danish health system, also came the risk of unintended fragmentation of the new system. Historically established formal and informal relations and organisational interfaces were broken down and disturbed (Strandberg-Larsen et al. 2007).

Despite great expectations from dominant Danish politicians, it has turned out that problems of fragmentation and silo barriers in Danish health care could not be solved simply by administrative restructuring (Strandberg-Larsen et al., 2007; Seemann 2004). The administrative reform has certainly resolved some difficult organisational interface and domain issues. Yet these solutions have themselves led to the emergence of new interface problems. This is especially visible in the area of rehabilitation (Vinge et al 2009).

There are still unclear divisions of responsibility among the various actors, including treatment/rehabilitation of patients discharged from hospital but who still require care after being released, and are now under the administration of the municipality (the hospitals have a quite different definition of the ‘released’ patient than the municipality). This theme has been discussed repeatedly in various regional and municipal forums.

The economic incentives, especially in establishing municipal co-financing in connection with hospitalization, have not worked as they were intended (Oekonomi- og Indenrigsministeriet 2013).

In sum, one can hardly label the Danish administrative reform as any sort of resounding success in terms of improving coherence in the health system.

In the following, we will further discuss two selected experiences from the 2007 reform in creating coherence in the Danish health system: the municipal co-financing of the hospitals and the organisation of new health tasks in the municipalities.

**Municipal co-financing of the hospitals**

There were great expectations about the reform from the central government and from the municipalities, but a more reserved reaction from the five new regions.

The following justification appeared in the text of the political agreement (Indenrigs- og Sundhedsministeriet 2004: 37-38, our translation):

*With a partial payment responsibility for the treatment of their own citizens in the health system, which depends on the citizens’ utilization of the health system, the municipalities receive a further incentive to provide efficient preventive care, rehabilitation and treatment.*

*The municipalities which, via an efficient preventive- and care effort, reduce the need for hospitalization are rewarded by having to pay less towards their citizens’ hospitalizations. The citizens benefit from having more of their needs significantly fulfilled in the local community, close to their own home and their own physician.*

The municipal co-financing of the region’s health expenditures, however, has not lived up to these expectations. On the contrary, the co-financing has tended to reinforce more sub-optimisation and
silo-style thinking. This does not enhance the municipalities’ incentive to pursue health prevention measures or to reduce the rate of re-hospitalization.

The co-financing is composed of a basic contribution per resident and an activity contribution per patient. The failure of the system is due to the fact that the basic contribution, naturally, gives the municipalities no incentive, and that the activity contribution is not adequately targeted, but applies to all types of illness, regardless of whether or not the municipality has the potential to prevent it. In addition, the co-financing system contains a co-financing of the general practitioners and physiotherapists, which is illogical in so far as it is these are two groups with whom the municipalities would want to ally themselves if they wanted to enhance prevention and prevent re-hospitalizations.

The municipalities’ expenditure for the basic payment did not give the municipalities any incentive to prevent needless hospitalizations and re-hospitalizations. The expenditure for the basic payment is independent of how many health services are used by the citizens.

As a result, beginning in 2012, there attempts to revise the municipal co-financing system. The fixed basic contribution has been eliminated and the ceiling on the variable payment raised. Experiences from this new restructuring are not yet available, since new kinds of municipal financing are still being discussed (KL et al., 2009; Oekonomi- og Indenrigsministeriet 2013).

The organisation of new health tasks in the municipalities
As mentioned above, the new health tasks taken on by the municipalities after the Structural Reform in 2007 were primarily those of health promotion and health prevention.

A research report (Hansen 2009:6ff) concludes not surprisingly:

In nearly all the municipalities and regardless of organisational model, it is mentioned that there is a great challenge in involving the management and staff in the various professional departments and institutions in the work of prevention and health promotion. The professional areas’ own operational tasks have first priority, and it does not necessarily give any more impact to be placed in a health department or a broader social and health department [Moreover,...] there is not one single general organisational model that has an advantage over others in terms of developing and implementing a preventive and health promotion programme in the municipalities’ various professional areas.

In principle, health promotion and prevention comprise an unlimited field, making the need for cross-cutting processes and inter organisational leadership especially important. The report leaves a clear impression that there is a need for more inter-organisational leadership competence. Leadership across both internal and external relations appears to be weak and underdeveloped. The municipal leaders are overly concerned with operations and act in a suboptimal way. They are hardly alone in this practice. Silo thinking is a feature of much management within the public sector – not least in the health care system (Ferlie et al. 1996).

In addition, it has been difficult for the municipalities to live up to the expectations of evidence-based initiatives and interventions. There is a lack of basic knowledge about what works, and the
municipalities have been accustomed to working in a more experience-based way. Hence, there is a tendency for the hospital administration to regard the municipalities as poorly equipped to take on their new health tasks.

**Explaining chronic integration difficulties in Danish health care**

Inspired by Kjellberg et al. (2007), we will discuss five factors behind chronic coordination difficulties:

**Complexity**

Because of the increased specialization within health care, the level of complexity also grows. Coordination with in and of health care is also impeded by the increasingly strong political control and vital importance of health in the welfare state.

**Organising**

A so-called unified and holistic patient or treatment process is not assembled in a single place within the healthcare system but is most often shared among a wide range of partners across sectors, policy levels and professions. In particular, the hospital organisation is an organisation with autonomous professionals in a bureaucratically decentralized structure. A major Achilles heel in the professional bureaucracy is the great difficulties with cross-cutting coordination. Hence, discussing the professional bureaucracy, Minzberg observes (1979: 372):

*Professional bureaucracies are not integrated entities. They are collections of individuals who join two draw on the common resources and support services but otherwise want to be left alone.*

**Health professionals and their professional cultures**

This explanation emphasizes the formal and informal relations among health professionals. These relations are characterized by the existing power constellations and by ongoing adjustments to internal and external conditions (Borum, 1997; Denise et al. 1999; Bentsen et al. 1999). Professions and professional cultures can create inertia in the system in relation to changes and developments. In this explanation, the professional cultures appear as a barrier to integration (Antoft 2005; Strauss 1982).

**Management**

One of the major challenges is that there exists no overall hierarchical management in the health care system as we might find in a traditional (monolithic) organisation. The health system’s many actors have connections to several different power and authority centers, and these often have vague and ambiguous relationships with each other (Gustafsson, 2007). In short, there is a lack of managerial competence in inter-organisational processes.

**Economy**
The final explanation relates to two economic factors: (1) which units are financially responsible for which parts of the treatment, and (2) the way they are financed. The first factor is crucial to so-called 'financial thinking', which occurs when focus is on only a single part (the profession, the clinic, the sector, the political level) rather than the whole. This kind of thinking is especially widespread across regions and municipalities, resulting in suboptimal solutions. The health system’s incentive structures are primarily adapted to the respective hierarchies. The incentive structures that reward cross-cutting processes and behavior continue to be in short supply in the Danish health system (Axelsson et al., 2014)

In this context, we should also mention a Canadian study (Denise et al. 1999) as a relevant supplement to the above-mentioned more well-known structural and cultural barriers in the health care system. The Canadian study cites three factors relevant to understanding the success of boundary redefinition initiatives in a health care system:

1. Emergent operating units.
   It is important to pay attention to the existence of the emergent, ‘negotiated’ organisational boundaries in professional organisations which coexist with the formal, structural boundaries. Professionals constantly and naturally coordinate across these boundaries in order to carry out their jobs. However, the unique form of coordination that takes place is developed and stabilized organically, through informal interactions. There are tacit, informal rules and relations of mutual trust that develop over time and create coherence among executing units. Any type of externally imposed reform or attempt to change practice must deal with these informal units and practices. Efforts at administrative change also face those power relations and incentives which structure emerging collaboration and produce the ‘locally negotiated order’ (Antoft 2005).

2. Differentiated professional influence.
   Organisational research (Pfeffer and Salancik 2003) has demonstrated that the actors or group who controls the uncertainty in a system has the greatest influence. Traditionally, doctors have been the most dominant group in the health sector, and this has resulted in role creation and hierarchical divisions among the other groups interacting with the doctors. Since changes in organisational boundaries often mean changes in established routines of collaboration, it is important not to ignore the role of the dominant professional group. In other words, we should expect that the doctors will defend their dominant position if they perceive it to be threatened.

3. Diluted managerial control.
   Several investigations have shown that administrative influence on executing (professional) levels is low and tends towards a classic, controlling administration. This kind of administrative practice tends to be more conservative than innovative. It reduces the options for the creation of new and different boundaries in the health system through management intervention. In other words, there are limits on the ability of administration to unilaterally compel professional actors to collaborate.

In summary, it is worthwhile citing the conclusions of the Canadian study:
Both intra-organizational and inter-organizational boundary-crossing initiatives aimed at improving integration must take into account emergent patterns of professional collaboration because these are both critical for success and elusive from control through administrative fiat or structural reorganization (Denise & Lamothe, 1999:112).

Summing up, it is reforms or reorganisations of the individual parts of the health system which have captured time and attention. Much work has been done to create changes in the Danish healthcare system, but the changes take place in a piecemeal, isolated way. It means strong tendencies to keep integration in health care a peripheral problem rather than the main problem.

**More priority to integration through inter-organisational leadership**

After at least four decades of efforts to improve the integration of health care across sector and organisational boundaries, we have seen only limited improvements. This is despite the increasing needs for coherent cross-sector patient flows (in complex cases). It appears that even comprehensive structural redesigns and formal collaborative agreements are insufficient to cut through silo barriers and bridge the boundaries of the many subspecialized units. They shortcoming may even lead to increased cost and cumbersome bureaucracy. The prevailing New Public Management (NPM) structures and management control systems within the silos should not be forgotten (Hood, 1991; Ferlie et al. 1994; Pollitt & Buckhardt, 2004). NPM is emphasizing efficiency gains and improved quality in a subtask perspective. As a result NPM constitute and anchor significant barriers to cross sector integration, and causing a massive sub-optimal thinking and action in health care with the result of fragmented care.

This suggests that strengthening horizontal integration must be based on a combination of a strengthening of inter-organisational leadership and a weakening of the centralized management control in narrow silo perspective. Seeing from the whole (Senge, 2005), it is a question of dynamic balance between vertical and horizontal management and between expertise-centric and patient-centric organizing.

There is no simple and easy recipe to achieve this balancing act. Even within a single organisation, the combination of vertical and horizontal organising gives rise to difficulties within existing knowledge (Seemann et al., 2015). Perhaps the rising new New Public Governance paradigm can provide a breakthrough with respect to this challenge (Torfing et al, 2013).

While awaiting this new paradigm, let us concentrate on some main arguments concerning enhancement of the horizontal perspective and leave behind the issue of “weakening” the vertical management to make room for horizontal management and integration.

The route forward to developing inter-organisational leadership involves a shift in mind-set, applying systemic innovation, supporting horizontal strategies, creating lateral network capability, leadership development and building trust and cultures of collaboration.

The shift in mind-set involves moving from focusing on one’s own profession to an integrated care perspective. In other words, moving from a patient-centric, sub-discipline perspective to a patient-
centric perspective that incorporates the whole picture of coherent patient flows across sector and organisational boundaries (Axelsson et al. 2014; Goodwin et al 2014)

Focus on systemic innovation entails continuous intersectional development of the whole patient process across involved parties. This involves balancing between the parties’ own separate directional innovations and the common systemic innovations (Seemann et al. 2013).

Supporting horizontal strategies involves a significant increase in attention to horizontal strategies from all levels of management, even when it interferes with silo perspectives. It also implies creating a lateral network capability, including appropriate forms of formalization of the network. However, there is a danger of over-organisation as well. Hence, it is of great importance to create simplicity and clarity in the formal structure of the networks. The nuances in the relations must be managed by expanding or building up the informal relations. The strength in the network derives precisely from flexibility and reciprocity based on informal relations and rules of the game (Denise et al. 1999; Seemann et al. 2002).

Leadership development entails training and education in leading cross-cutting activities, adaptation- and influence processes and the management of dilemmas in complex, dynamic value-creating processes. Traditional management roles and functions will not succeed here. Furthermore, it is important to understand how cross-cutting principles modernize and interact with traditional leadership forms.

With management that must cut across hierarchies, one can draw on positional power only to a limited extent. Cross-cutting leadership is not yet a formal position category, and in order to manage complex processes, this kind of leadership platform is significantly more delicate than line-managers’ positional hierarchy. A clarification of one’s own leadership role within the health systems’ cross-cutting relations is itself an important part of this leadership

Cross-cutting leadership is not just about coordination and cooperation. It is also about concrete problem solving. It is absolutely critical that network leaders are task-oriented. Cross-cutting teams do not simply take on coordination, planning and decision-making, as we observe in traditional bureaucracies. The teams must also carry out tasks and execute decisions. Cross-cutting coordination and problem-solving melt together. It can be important for a dominant party to act as ‘guide dog’ and thereby create the basis for operational organisation. But it is just as important that the dominant party is compelled to see and to include the other parties in the organisation and management of operations. Otherwise, the other parties will retreat, resulting in a loss of essential knowledge, resources and involvement.

Finally, and probably most important, inter-organisational leadership depends heavily on building trust between the parties involved. The concept of ‘trust’ is emphasized in most of the inter-organisational network literature (Lane 1998; Huxham & Vangen 2005). It is as it has always been: We work together with those whom we trust, and conversely, we find it difficult to work with those whom we do not trust. Trust is an artefact of relations between actors. Hence, it is very important to
develop cultures of collaboration, creating the kind of ‘inter-organisational glue’ that can avoid silo barriers and fragmented health care.

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