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Social movements and the contested institutional identity of the hospital

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ABSTRACT

Taking popular protest as a common reaction to changes in hospital services as its point of departure, this paper explores how a social movement has taken on the issue of the *hospital as an institution*. In the wake of the transformation of Norwegian public hospitals into health enterprises (trusts), this paper explores community resistance to the proposals and plans of decision-makers to restructure hospitals. The study is based on a qualitative and quantitative analysis of the website/blog for the local hospital movement's activities from 2007 until 2017 and of its involvement and resistance in respect of three instances of proposed change to the hospital structure during this period. The study reveals that the health enterprises and the managerialism they represent pose a threat to individual safety and sense of belonging, and to the preservation and identity of the local community. Moreover, the framing of the cause of the local hospital movement illuminates how the institutional identity of the hospital is highly contested between the institutional categories of 'public administration' on the one hand, and 'the company' on the other. The impact of the local hospital movement has proven modest in terms of influencing and reversing decisions to restructure hospitals, but it has been considerable in terms of cultural support for its concepts and values, not just concerning hospitals and health care services, but also with regard to democratic governance.

1. Introduction

Proposals to merge, move or close hospitals and other health-care services will invariably meet with strong reactions (Barratt and Raine, 2012; Barratt et al., 2015; Brown, 2003; Fredriksson and Moberg, 2018; Jones and Exworthy, 2015; Kearns and Joseph, 1997; Stewart and Aitken, 2015). To express their opinions and concerns, and to influence decision-makers to withdraw or reverse such proposals, people hold marches and meetings, sign petitions and publish letters, and use social media. From the protesters' point of view, access to health services is but one of several concerns. Other consequences, such as job losses and increased risk to other services, are also feared (Farmer et al., 2012; Stewart, 2019). Interestingly, this occurs not only in small, peripheral towns, which are more vulnerable in terms of services and other assets, but also in big cities, even in capitals like Oslo and London (Moon and Brown, 2001). These findings indicate that to understand the meaning of a hospital we need to go beyond medical expertise and managerial concerns and recognise what a hospital may mean from a community perspective (Barratt and Raine, 2012; Barratt et al., 2015; Borum, 2005; Jones, 2015; Stewart, 2019). According to Stewart, we need to 'go beyond testing public appetite for clinical rationales towards understanding the lived experience of services in their communities' (2019, p. 1265). In other words, research on community hospital activism should be redirected from hospitals as buildings which contain healthcare to hospitals as socially and historically significant institutions (Jones, 2015; Stewart, 2019). Popular reaction to and protest against such processes of change thus illuminate the symbolic and emotional significance of hospitals (Brown, 2003; Kearns and Joseph, 1997; Kearns, 1998; Stewart, 2019), making this a much more complex issue than a mere question of access and distribution in terms of health services (Barnett and Barnett, 2003; Panelli et al., 2006). Trust in decision-makers and health care as a whole, together with their legitimacy, is also at stake (Oborn, 2008).

Previous research has provided rich insight into the complexities of restructuring health-care services and facilities, and the impact of popular protest on such strategies (Brown, 2003; Foley et al., 2017; Jones, 2015; Oborn, 2008; Stewart, 2019). However, we think that the understanding of this phenomenon would benefit from a closer look into areas capable of supporting, supplementing and complementing this body of knowledge. Firstly, much of the literature on resistance to the restructuring and decommissioning of health care takes single protests, campaigns and action groups as its point of departure; there has been a

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call for research which covers a longer time span and includes multiple cases (Ferlie, 2001; Fulop et al., 2012). Secondly, the existing research is dominated by such disciplines as cultural geography (Brown, 2003; Kearns, 1998; Moon and Brown, 2001) and sociology (Stewart, 2019) and employs, e.g., place identity (Kearns, 1998), discourse (Brown, 2003; Moon and Brown, 2005) and legitimacy (Oborn, 2008) as conceptual and theoretical approaches. The relevance of these approaches is clearly demonstrated. Yet, in order to capture the breadth and depth of time and space in such activism, we also regard health social-movement research and social movement theory, which are largely absent from the literature on hospital activism, as equally relevant and central, insofar as the social-movements approach highlights conflict and contestation, as well as collective action and mobilisation. Finally, the research literature on community engagement regarding hospital restructuring is dominated by studies originating in England, Scotland, Ireland, Australia and New Zealand; empirical research is scarce from other regions, such as the Nordic countries, that are known for universal health-care systems. To our knowledge, such research is limited to the study by Fredriksson and Moberg (2018) of decommissioning proposals after the 2008 financial crisis in Sweden.

In this article, we seek to provide new insights into the contested nature of health-care institutions. In order to achieve this, we explore the hospital as an institution whose meaning is processed by different social actors, resulting in conflicting interpretations and 'projects' (Borum, 2005, p. 114; Stewart, 2019). We achieved this by conducting a longitudinal and multiple case study of a social movement protesting restructuring proposals and decisions related to local hospitals in Norway.

2. Background and research questions

In 2002, the Norwegian government introduced a health enterprise reform that transferred ownership of hospitals from the counties to the state. This engendered much debate and opposition, as it constituted a break with the decentralised Nordic governance model. Previously, specialist health-care services were the responsibility of regional political authorities; the health-enterprise reform thus weakened the democratic influence over hospitals (Magnussen et al., 2009). Beginning in 2002, five *Regional Health Authorities* (RHFs) with professional boards were given autonomy over and responsibility for organising and running *Health Enterprises* (HFs) (i.e., clusters of hospitals). State-level politicians were intended to govern HFs at arm's length, primarily by making decisions about funding and financing health-care, as well as about general health sector legislation (Byrkjeflot and Neby, 2008). This new governance model also introduced 'managerialism' into the Norwegian hospital sector; i.e. it introduced managerial autonomy, accountability, strategic thinking, performance management and management by objectives into the hospital sector (Klikauer, 2015; Lægreid and Neby, 2016).

One of the main strategies of health enterprises is to use formal organisation as an instrument to manage hospitals. This approach is often referred to as 'decommissioning' or 'disinvestment', which constitutes an instrumentally planned organisational change for achieving cost-effectiveness, improved quality and managerial control by way of removing, reducing or replacing health services (Fredriksson and Moberg, 2018; Williams et al., 2017).

In response to the health enterprises' change strategies, *The People's Movement for the Protection of the Local Hospital* was established in 2003. This movement is a politically independent and bipartisan national network of local action groups (lokalsykehus.no) and other actors who support the idea of protecting and promoting a decentralised hospital structure, including the Municipalities Association for Local Hospitals, the Alliance for the Welfare State, Health Service Action and the Norwegian Union of Municipal and General Employees. It also has support from other unions, individuals and groups of professionals and politicians from all parties. The organisational resources of the movement are limited to an unpaid national coordinator and four regional coordinators who administer the blog/website and organise an annual convention and demonstration.

To understand the aims and concerns of the local hospital movement, as well as the impact it might have, we chose to do a longitudinal study of the activities of the People's Movement for the Protection of the Local Hospital from 2007 to 2017; in addition. we examined three different cases of reactions to proposed hospital restructuring during this period. Our study is guided by the following research questions: What is at stake for the local hospital movement when some perceptions, ideas, values and interests concerning the hospital institution are promoted and others are opposed? What impact does the movement have on hospital governance?

3. Theoretical approach

Historically, social movements have played an active part in the agenda-setting processes in health policy and the development of health-care systems and services (see e. g Brown and Fee, 2014; Brown and Zavestoski, 2004; Epstein, 2008). Research on social movements and health care has primarily focused on how social movements promote the equitable provision and distribution of health-care services (*health access movements*), on the experiences and needs of certain patient groups (*embodied health movements*), and on the rights and needs of certain population groups in respect of health-care access and services (*constituency-based health movements*) (Brown and Zavestoski, 2004, pp. 685–686). All of these put patients (or their proxies) and/or the medical and scientific issues at the centre of their movements' focus and political concerns, and at the centre of their struggle for institutional change (Brown and Zavestoski, 2004; Epstein, 2008; Levitsky and Banaszak-Holl, 2010). Community activism and collective resistance against policies aimed at restructuring health-care organisations and decommissioning health-care services, are clearly concerned with access to health-care provision. However, they seem to be broader-based than illness- and patient-centred movements, and the constituency is geographically constituted rather than group-based. Still, this movement shares engagement with institutional change in health care with other types of health social movements.

Della Porta and Diani (2006) regard social movements as a process that motivates people to participate in collective action. Collective action is triggered by conflict, sustained by informal networks and collective identities and aimed at either promoting or opposing change and challenging authority structures (Brown and Zavestoski, 2004; Della Porta and Diani, 2006; Tarrow, 1998). In other words, conflict, change and collective action comprise the core of social movements, and social movements' attention centres on institutions (McCarthy and Zald, 1977). Consequently, social movement research and institutional theory are clearly interrelated (Schneiberg and Lounsbury, 2008). One approach to this relationship is to explore how institutions are challenged by movements that contest their existing order, structures, arrangements and legitimacy to promote institutional change (Meyer, 1996; Schneiberg and Lounsbury, 2008). Another angle is to consider how 'movements emerge from and exploit contradictions or multiple logics within fields to mobilize support, forge new paths or produce change' (Kitchener, 2010; Schneiberg and Lounsbury, 2008, p. 652; Thornton et al., 2012). Given that our main interest is in the cultural and symbolic aspects of health care as described in the introduction, we will emphasise and elaborate on social movements as cultural opposition (Campbell, 2005; Della Porta and Diani, 2015). Here, the emotional, symbolic and expressive aspects of engagement and action are key (Jasper, 2011). Social movements are defined by how they construct, promote and protect certain values and ideas. Actors participate on the grounds of identity, conviction and belonging. In relation to institutions, people may be committed to the values that institutions embody or, conversely, they may reject institutions depending on their value judgements (Friedland, 2018; Lok et al., 2017; Suddaby et al., 2017;

Zietzma and Toubiana, 2018), which may serve as the foundation for engagement in collective action and social movements.

Framing is key within this perspective and functions through the use of cognitive mechanisms to produce schemata or scripts to make sense of the world (McAdam and Scott, 2005; Snow and Benford, 1988). This entails the way in which some aspects of reality are selected in order to promote a certain way of defining a problem or a situation, a certain causal relationship or a certain value judgement (Entman, 1993). To create and express a common understanding of reality, symbolic means are used (Snow et al., 1986), examples of which include the use of narrative (Polletta and Gardner, 2015), art (Eyerman, 2015) and (other) rhetorical means to both express and invoke the logos, ethos and pathos of a cause (Friedland, 2018). This emphasises the intentional and strategic aspects of meaning-making in and by social movements, and not merely the diffusion of taken-for-granted perceptions of reality (Schneiberg and Lounsbury, 2008).

4. Methods

While the present study was intended to follow up research we conducted on the local hospital movement in 2012 (Anonymous, 2014), we actually ended up including the data from our previous work in order to examine the protests over a longer period and at more locations. We employed the following approaches to the empirical study of the local hospital movement: a quantitative and qualitative content analysis of the blog and website of the People's Movement for the Protection of the Local Hospital and qualitative case studies of three proposed hospital restructuring processes.

To gain an overview and greater understanding of the issues with which the movement is engaged, as well as its perceptions, values and opinions, we analysed the movement's blog/website postings from 2007, when the blog was launched, until 2017. As a collection of material on health and hospital-related issues, the blog/website is the closest we have to a voice for the local hospital movement in general. Yet activists rarely write and publish their own articles; most of the postings are uploads of media coverage (both news media and sector-related publications), research reports, health policy documents, white papers, etc. On behalf of the movement itself, the postings comprise mostly announcements for annual national meetings and demonstrations, although sometimes a 'statement' is released on the movement's opinions on the principles of hospital policy and on concrete issues of hospital reorganisation. Throughout the period as a whole, activity levels varied from intense activity to near hibernation: 633 postings in 2008, 587 in 2010 and only 33 in 2015. These variations may relate to the launching of reforms, policies and plans for the health and hospital sector, both nationally and locally, as well as to elections and extra controversial cases which attracted a great deal of attention; the variations are probably also related to the capacity of the coordinator (interview, March 2018) and the parallel and growing use of platforms such as Facebook. Repeated readings of the blog/website allowed us to produce categories with which we could map the movement's main interest areas. We counted the number of postings within each unfolding category in order to determine their relative importance. We also conducted an interview with the national coordinator for the People's Movement for the Protection of the Local Hospital in order to understand how the movement is organised and operated.

To study the movement in action, we chose three cases in which a plan to change the hospital structure regionally or locally had been launched and examined how these plans were received and reacted to until a decision was made. Two of the cases involved typical local hospitals in the periphery: Rjukan Hospital and Odda Hospital. The third case involved Sørlandet Hospital Arendal (SSA), which is more centrally located. The events occurred in 2010 (Arendal), 2013/14 (Rjukan) and 2016/17 (Odda), and each case had a different outcome. Our aim was not to compare the cases in order to explain their outcomes but, rather, to cover variations in time, space and outcome in order to gauge the movement's ideas and activities in context and thus accumulate knowledge and a deeper understanding of the phenomenon (George and Bennett, 2005).

The data were derived from several different sources, including the media coverage (found in the media archive Atekst and at lokalsykehus.no) of all three events. We also gathered relevant documents on the events, such as internal reports, plans and minutes from health enterprise board meetings and national policy documents. In addition, we analysed sources of particular relevance to each of the three events, as different modes of expression were in use and thus available to us in different contexts. These sources include social media activism in the Odda case, artefacts at Rjukan and field observations of the protest in Arendal. Finally, in order to get an overview of the local contexts, we interviewed leaders and coordinators of the protest actions in Odda and Rjukan and conducted a group interview with members of the protest group in Arendal. We believe that this diversity of empirical sources yielded a richer, more holistic understanding of both the events and the movement, an understanding which, surveys and interviews alone, for example, could not have produced. In our analysis of the case material, we took the categories of internet postings (see below) by the People's Movement for the Protection of the Local Hospital as our point of departure. The materials derived from each of the three cases were analysed interpretatively by way of focusing on the phrases, metaphors, arguments and identity claims that are components of frames (Cornelissen and Werner, 2014). Combined, the two sets of data served to identify four central themes in the local hospital movement: 1) safety in case of emergency, 2) the relationship between people and their local hospital, 3) the consequences for local communities and 4) the health enterprises' management of hospital services. These themes are elaborated on in the findings section and constitute the foundation of the frame analysis and discussion.

5. Findings

In this section we present and analyse our data and empirical findings in three steps. Firstly, we present a quantitative content analysis of the postings on the blog/website of the People's Movement for the Protection of the Local Hospital from 2007 until 2017. Secondly, we present the three cases: the background, the events and the result of the protest activity. Thirdly, we analyse the three cases and the content of the blog/website in terms of the four themes that frame ideas of the local hospital movement about the hospital as an institution.

5.1. The People's movement for the protection of the local hospital and the content of its blog/website

Taken together, obstetrics/maternity and emergency services are by far the biggest category, with 939 postings, which is not surprising considering that such services represent the main functions of local hospitals. A great number of local hospitals in Norway are referred to as being under threat at one point or another, and there are many recurring cases. More striking is the number of postings on health enterprises and New Public Management: 489. This indicates that the movement is interested in the organisation and management of the entire hospital sector and has specific opinions about its operation and effects on services and developments in the sector as a whole.

Interestingly, hospitals located in the capital, Oslo, were of particular interest (216 postings) to the movement. This may be attributable to the fact that, in 2009, two national hospitals and a third hospital (Ullevål) in Oslo were merged into what is now Oslo University Hospital; in the meantime, another hospital (Aker) was closed and its patients transferred to a hospital outside the city. Because Ullevål and Aker hospitals had once served as local hospitals for the inhabitants of Oslo, they became an area of interest to the movement (Table 1).

Table 1
Distribution of blog posts by The People's Movement for the Protection of the Local Hospital, 2007–2017.

Categories	Number of blog posts
Health policy and economy	571
Health enterprises and NPM-inspired steering	489
Obstetrics care	333
Emergency services	317
Local hospitals	289
Oslo University Hospital and Aker Hospital	216
Activism and actions	172
Total	**2387**

5.2. Three cases of protest against decommissioning proposals

The first hospital in Arendal was built in the 1750s. In 1915, the county decided to build a new hospital to serve all its residents. The hospital in Arendal went by the name Aust-Agder Central Hospital Arendal until 2003, when the health enterprise reform was implemented. Sørlandet Hospital Arendal (SSA) is now one of three remaining hospitals in the Hospital of Southern Norway Trust (SSHF). In this case, a proposal was made in 2010 to reorganise the treatment of stroke patients. The management of SSHF supported a solution which would involve centralising the neurological emergency service at Sørlandet Hospital Kristiansand (SSK), thereby reducing the capacity for neurological treatment at the other two hospitals. This also meant that the internal medicine departments at the other two hospitals would have to treat stroke patients with telemedical support from SSK (Board of SSHF, item 96/10). The proposed model met with strong disapproval and opposition in Arendal, both inside and outside the hospital. On October 12, 2010, a massive demonstration took place. On 21 October, the employees of SSA collectively declared their distrust of the management of SSHF. Union leaders from SSA and local Labour Party representatives met with the Minister of Health and Care Services to petition on behalf of the hospital. Despite this, on 26 October, the board of SSHF endorsed the proposed reorganisation of emergency neurological treatment. As 'consolation', SSA was promised that, in the future, the distribution of services and organisational units between the hospitals within SSHF would be 'balanced' (Board of SSHF, item 96/10).

The precursor of Rjukan Hospital (RH) was a health service established and operated by the industrial giant Norsk Hydro in 1906. Rjukan Hospital had been threatened with closure a number of times and, underwent numerous reorganisations and restructurings as part of Telemark Hospital Trust (STHF). RH's main activities in 2013 were planned and scheduled orthopaedic surgery and rehabilitation. However, the presence of surgical staff meant that the hospital could maintain an emergency ward and treat acutely ill patients and accident victims. In the autumn of 2013, the director of the health enterprise proposed closure of surgery and emergency treatment at RH and, consequently, the end of round-the-clock services. This was not well received in Rjukan, not least because the Minister of Health and Care Services had proclaimed that no hospitals with maternity wards and emergency facilities would be closed before the completion of a National Health and Hospital Plan (NHHP).

In the following months, a variety of protests took shape, including letters to the editor in local and regional media, the main message being: *Don't touch Rjukan Hospital* (blog post, December 14, 2013). In addition, a private initiative was launched to create an exhibition in support of the hospital at a gallery in the centre of Rjukan. Despite all the protests, the boards of both STHF and the South-Eastern Norway Regional Health Authority endorsed the closure of Rjukan. Hospital. Since the Minister of Health and Care Services did not want to overrule the autonomous regional health authority, a 'rescue' proposition was made by the Centre Party to the Storting, Norway's parliament, to postpone the decision until after the NHHP was launched (Dokument 8:25 S (2013–2014); Innst. 199 S (2013–2014)). Busloads of people from Rjukan and the surrounding towns and districts went to Oslo to demonstrate in front of the Storting on June 16, 2014, when the proposition was voted on. The proposition, however, failed to get majority approval and the emergency ward was closed later the same year, while orthopaedic surgeries stopped the following year.

The third case involves responses to the proposed closure of emergency surgery services at Odda Hospital (OH) in 2017. Odda Hospital opened in 1918 as a municipal local hospital and, like RH, OH had survived numerous threats to its operations both before and after ownership was transferred from the county to the Helse Fonna HF hospital trust (HFHF) following the 2002 reform.

When launching the NHHP in the White Paper Meld. St. 11 (2015–2016) in 2015, the Minister of Health and Care Services delegated responsibility for considering the emergency surgery services at some of Norway's smallest local hospitals, including OH, to the regional health authorities. A project group was established in March 2016 with members from Odda Municipality and OH, as well as other specialists in primary health care and the managing directors of both the Western Norway Regional Health Authority (HVRHF) and the Helse Fonna Trust. The project group reached an impasse: a minority, consisting of the health enterprise directors and the project leader, emphasised cost efficiencies and problems with recruiting specialists in surgery and trauma treatment and were thus in favour of closure. The majority were more concerned with adverse weather and road conditions in the area, such as frequent rockslides, avalanches and floods and the resultant risk of road closures and accidents. Such scenarios would lead to longer distances to the nearest hospital with emergency surgery services, which would pose unacceptable health and safety risks. Despite this impasse, the powerful minority appeared to gain the upper hand, which was perceived as undemocratic and illegitimate by hospital activists.

That winter (2016/17) numerous protests and torchlight processions took place, and social media posts aimed at influencing decision-makers proliferated on the Fight for Odda Hospital group on Facebook. Despite these attempts, the boards of HFHF and HVRHF recommended the closure of emergency surgery at OH. However, a 'rescue' proposition was put forward in the Storting by representatives of the Christian Democratic Party and the Socialist Left Party. With regard to OH, the main argument was that the risks of longer transport distances for seriously ill and injured patients were too great. With the support of the Labour Party, on May 15, 2017, the Storting endorsed the proposition to continue emergency surgery services at OH (Innst. 275 S, 2015–2016).

5.3. Four ways of framing

5.3.1. Safety and security

Plans to close or substantially reduce emergency units and maternity wards are particularly provocative. These services are, of course, clearly connected to questions of life and death. The local hospital movement exploits this powerful concern by suggesting that deaths due to accidents and difficult childbirths will increase should local hospitals and services disappear. The platform of the People's Movement for the Protection of the Local Hospital that was issued in 2011 emphasised that 'the country's geographical conditions, harsh climate, mountainous topography, long coastline, dispersed population, etc, necessitate a distributed hospital structure to ensure safety, especially with respect to crises and births'.

Childbirth is an especially emotional event, but it is also potentially dramatic. The movement has emphasised this by posting stories about women forced to give birth in ambulances, taxis and parking lots, among other places. This was also highlighted in the exhibition in support of the hospital in Rjukan: 'Thanks to Rjukan hospital, my baby girl is alive … If I'd had to go to another hospital in an ambulance, she probably wouldn't have lived.'

Having a hospital nearby represents a sense of security, especially in the event of accidents and other crises. One such crisis was the extreme storm that engulfed Western Norway during Christmas 2011, the

aftermath of which was used to highlight the need for emergency preparedness with a distributed hospital structure, one which preserves local hospitals (blog posts of December 29, 2011, December 31, 2011 and January 14, 2012). References to this crisis were also an important feature in the mobilisation in Rjukan in 2013 and 2014. Local activists sent postcards to the Ministry of Health and Care Services that read 'Learn from Lærdal', referencing a serious fire that had occurred in this remote town: the local hospital was identified as the main reason that no lives had been lost during the disaster.

'Security, closeness and time mean everything' is the title of a personal story shared in Rjukan in which the writer describes how both her child and her father had received lifesaving treatment at RH (exhibition at Galleri Taide, Rjukan). Other story titles include 'The emergency ward saved my life' and 'Stabbed with a knife in his own home – he would have been dead without emergency surgery services in Odda' (lokalsykehus.no, March 27, 2017). Thus, the importance of local hospitals and their fate in the decommissioning processes have become a matter of life and death.

The demand for specialist treatment and services, and not just emergency services, is also connected to the drama of life and death. The torchlight procession in Arendal on October 12, 2010 was directed particularly at the board's suggestion that the neurological department be closed as part of a reorganisation of SSHF. Brain stroke is a serious condition where time and thus proximity to a treatment facility are often crucial to the ability to survive with as little damage to the brain and neurological system as possible. Another significant feature in this particular protest rally was a mobilisation to maintain round-the-clock preparedness in the children's department with the slogan 'The Obstetrics Ward needs the Children's Department,' demonstrating how this proposed change was perceived as a threat to both the quality and scope of services in both departments. The fight for preparedness for stroke treatment and the defence of services and treatment for children shows that events and sentiments connected to life and death dominate perceptions of reality and that conditions and questions are key in the construction of meaning as well as in opinions about what a hospital is and what it should do.

5.3.2. *The emotional ties between hospital and community*

The heart has become the main symbol of the local hospital movement and its activities. In Arendal, the slogan was *SSA is in our hearts*. In Rjukan, 600 hearts cut from red construction paper, with slogans and greetings addressed to RH and its staff, were exhibited in the small gallery space to express love for the hospital. One of the exhibited hearts bore the inscription 'Help. I was born there', suggesting an intimate relationship between the inscriber and RH. Besides emphasising the sense of safety that having a hospital provides, the testimonies exhibited in Rjukan expressed the gratefulness of former patients for the service and care of the hospital staff in statements such as 'Competent, kind and caring', and 'I was treated like a king.' The postcards addressed to the Ministry of Health and Care Services petitioned for the rescue of RH with a combination of red hearts and a heart rate curve to amplify the connection between hard knowledge and the technologies for monitoring and saving lives, as well as to emphasise the mutual care between people and the hospital.

A strong sense of identification between the movement and the hospital is clearly expressed in slogans for local hospital actions: *Defend the hospital*, *Preserve the hospital*, *Let the hospital live*, *Protect the hospital*, *SSA is in our hearts*, *Don't touch Rjukan Hospital* and *We're passionate about Odda Hospital*. As mentioned earlier, the local hospital movement is concerned not just with peripheral towns in Norway, but also with major cities, including Oslo. In late 2010, 36,000 people concerned about losing 'their own hospital' signed a petition to preserve Aker Hospital in Oslo (blog post, February 16, 2010). This in turn emphasises that hospitals, in general, have symbolic significance and meaning that transcend access to medical treatment and care and that the local protests convey a strong sense of individual and collective affiliation with the local hospital (Brown, 2003; Kearns and Joseph, 1997; Kearns, 1998; Moon and Brown, 2001; Stewart, 2019).

5.3.3. *Life and death of the local community*

The local hospital movement's proclamation at a national rally in 2011 stated that 'the government's decision is also an attack on rural Norway because it weakens the opportunities for local communities to keep on competent people and recruit them to a diverse economic structure. It undermines the efforts that are made in many places to get young people who have moved away for an education or a job to move back home' (blog post, November 10, 2011). Tinn Municipality, where RH was located, issued a report about how closing the hospital would affect the entire community in terms of not just health and safety but also employment, business and other local services, both public and private. The direct job losses due to the board's decision were estimated at 100 positions, with no possible compensation, and therefore the effect of the decision was considered to be dramatic. The combination of reduced health-care services and job losses, in both the hospital and other sectors and businesses, would result in the loss of the community's most important resources (Vareide, 2014). This was also expressed by individuals on the red paper hearts exhibited in Rjukan in statements such as 'Cornerstone and foundation', 'Save the local community. Save Rjukan Hospital'. In other words, the hospital is regarded as an asset whose significance transcends medical treatment and the care of sick and injured people – the hospital saves *places*, not just people (Farmer et al., 2012).

Strategic allocation plans for specialised medical functions, as well as concomitant suggestions for merging or moving hospitals or departments, collide with the symbolic significance of the hospital to the town's status (Grønlie, 2004; Jones, 2015; Stewart, 2019). This was clearly expressed on posters carried during the event in Arendal in 2010. Arendal residents feared that SSA was going to be reduced to a 'community hospital' like those in smaller, more peripheral areas. One of their main slogans was 'Are people from the west more valuable than people from the east?', expressing the view that health enterprise management was ranking citizens according to geographical criteria. This in turn suggests that its actions were being interpreted in a particular context: that of the long and deeply rooted fight over economic, cultural and political significance between Arendal and other towns, and between the counties in which they are located. In Odda, one of the lines in a poem shared numerous times on Facebook ironically stated that *soon you can e-mail your appendix to Haugesund* (Facebook, April 4, 2016), indicating the frustration of losing hospital services to the bigger hospital in the bigger town by alluding to how small places have lost postal services. This shows a perception that *our town* will not be *the same* without the hospital as a symbol of the city's status and heritage (Barnett and Barnett, 2003, p. 61).

5.3.4. *Against health enterprises*

A substantial portion of the blog postings in the period 2007–2017 concerned health enterprises. Nationally, there have been two waves of criticism against the health enterprise model – the first was in the wake of an alternative evaluation of the health enterprise reform in 2007 (Jensen and Bollingmo, 2007; Marstein et al., 2007 . In December 2008, many posts about and against New Public Management were made, particularly with regard to how this governance approach towards hospitals was undermining health services and the welfare state. 'The hospital is not a shop' and 'The patient is not a commodity' are two examples of such posts.

The other wave of criticism of the health enterprise model occurred in connection with the commission on the government and organisation of the hospital sector. The local hospital movement had hoped that the commission's Green Paper (NOU 2016:25) would spell the end of the health enterprise model and, consequently, that more national and local democratic control would be reintroduced into the hospital sector. This, however, was not the case; instead, the Green Paper recommended that

autonomous enterprises continue as a preferred governance model for the hospital sector. In response, the local hospital movement used the health enterprise model as the subject of its convention in September 2017. In a statement issued on 3 September (lokalsykehus.no), the movement declared that it wished to replace the enterprise model with a democratic model, and that doing so was essential for restoring trust in the authorities, by holding elected representatives accountable, opening up decision processes and entitling local communities to exert influence on health and hospital services. Furthermore, the movement stated that business accounting, activity-based financing and corporate boards should be abolished, and that 'instead of running hospitals like shops, it's the patients' needs that should steer the services.' A letter was also sent to the Conservative Party and the Labour Party with the following demand: 'that the health enterprises be closed down and replaced with democratic government in the hospital sector based on the principles of public administration of welfare services' (lokalsykehus.no, April 9, 2017).

Locally, as the three cases demonstrate, trust in the health enterprises and their legitimacy were nearly non-existent; instead they were regarded as an enemy, both in general and in relation to specific plans, decisions and local hospitals. In Arendal, the employees of SSA collectively declared their distrust of the management of SSHF with regard to how the hospital structure was treated before the board had even reached the conclusion to remove emergency stroke treatment from SSA. One indication of the heated atmosphere between local protesters in Rjukan and the health enterprise was that when the director of the health enterprise met with the staff of RH in December 2013 to present the plan to remove all surgical and emergency services from the hospital, at least 3000 (out of a population of 6000) demonstrators turned up; the director required police assistance to get out of the car and enter the hospital (blog post, December 14, 2013). Another incident that illustrates the distrust towards health enterprises occurred when a clinic manager from STHF demanded that the exhibition of support statements for the hospital be stopped because some of those involved were also employees of RH. The manager was concerned about the mixing of roles, loyalty to the organisation and patient confidentiality (Letter, February 27, 2014). This soon became a question of freedom of speech, with the gallery owner complaining to the Minister of Health and Care Services about the health enterprise's interference (Letter, May 16, 2014).

In Odda, the issues of the decision-making process and the local and regional health authorities' decisions to remove emergency surgery from OH were raised. Although the project group that was supposed to analyse the matter and suggest solutions had representatives from the local community and OH – which, incidentally, is recommended by decommissioning best practice (Williams et al., 2017) – the fact that the minority overruled the majority in the end suggested that the composition of the project group was symbolic. Accordingly, local activists did not trust the minority report or the health enterprises' promise that the funds saved by removing emergency surgery would be spent on strengthening other areas of services and activities at OH. There was speculation that the funds had instead been earmarked for a new hospital building in Haugesund – the largest hospital in the local HFHF hospital cluster – from the outset (Facebook, May 4, 2017).

These findings suggest that enterprise governance of public hospitals is associated not only with decommissioning and the consequences of this in the eyes of the local hospital movement but also with decision-making processes that lack legitimacy. This illuminates how deeply rooted the trust and legitimacy issues are, as well as how hospital structure and hospital governance are embedded in the social, cultural, political and moral tensions of society (Borum, 2005; Oborn, 2008).

6. Discussion and conclusion

In this article, we have explored the actions and words of the local hospital movement from 2007 to 2017 by analysing the blog/website of the People's Movement for the Protection of the Local Hospital and three cases of protest against plans to reorganise hospitals. The people's intense engagement in this movement is a critique of the organisational strategies of decision-makers, as well as a way of paying tribute to and promoting certain norms and ideas about what a hospital should be, what it should do, and how it should do it.

By studying how the hospital movement frames (Cornelissen and Werner, 2014; Entman, 1993; Snow et al., 1986; Snow and Benford, 1988) the meaning of the local hospitals and how they are governed, we have revealed that what is at stake is the identity of the hospital institution, as well as the legitimacy of the current governance model.

Our findings suggest that there are four main ways in which the local hospital movement frames its cause: 1) the local hospital is crucial to personal safety and security, 2) people are emotionally attached to their local hospital, 3) the local hospital is a material and symbolic asset for the local community and 4) the health enterprises and the managerialism they represent pose a threat to individual safety and sense of belonging, and to the preservation and identity of the local community. The first three frames are well known from other research into community protest against the decommissioning and restructuring of hospitals and health services (see e.g. Barnett and Barnett, 2008; Fredriksson and Moberg, 2018; Kearns, 1998; Moon and Brown, 2001; Stewart, 2019), whereas the fourth way of framing the cause concerning the governance model reveals a wider and deeper scope of Norwegian local community resistance against these strategies and changes.

The scope of the resistance must be understood in relation to how certain conceptions of reality and values are safeguarded or, conversely, threatened by particular institutional and organisational arrangements (Friedland, 2018; Lok et al., 2017; Zietzma and Toubiana, 2018) and how in this case the hospital is defined in relation to institutional affiliation (Brunsson, 1994) or institutional categories (Glynn, 2008).

Brunsson's (1994) typology of institutional affiliations – according to political organisation or company – highlights their origin and legitimacy. Political organisation affiliation relates to citizens' influence via free and fair elections, accountable representatives and public utility (i.e. democracy), whereas company affiliation is based on customers, competition and efficiency (Brunsson, 1994, pp. 324–325). Our findings clearly demonstrate how the local hospital movement can be considered a quest to recategorise hospitals as public administration by emphasising the political aspects of health care and hospital services and how these should be organised and governed (Magnussen et al., 2016). The engagement of the People's Movement for the Protection of the Local Hospital in the governance of hospitals in 2007/2008 and in 2017 assumed the form of attacks on the managerialism of the health enterprise model. What the movement promotes is local and national democratic accountability and control together with transparent decision-making processes with broad participation, including local representation and influence in accordance with the traditional way of governing public hospitals (Magnussen et al., 2009). Moreover, the insistence that this governance model is based on marketisation, commodification of health services and treatment, and the customerisation of patients, clearly indicates opposition to the perceived change in institutional affiliation or identity of the hospital. Furthermore, all three cases demonstrate resistance to the health enterprises' mode of decision-making, as well as to the content of the decisions made on hospital structure within their jurisdictions, with reference to unfair processes and unfair outcomes that ignore local needs, preferences and identities. In other words, the local hospital movement rejects 'companyisation' (Brunsson, 1994) and enterprising managerialism (Du Gay, 1994; Klikauer, 2015; Spicer and Böhm, 2007) as being inappropriate and not in alignment with the movement's perception of the hospital as an institution. Similarly, public administration is advocated as the proper form of organisation and governance of health care.

Turning to our second research question, concerning the impact of the local hospital movement on hospital governance, our findings clearly illuminate how the movement moves and activates its frames whenever and wherever the health enterprises activate their

restructuring strategy. Not only does the movement pose a constant and continuous challenge to the legitimacy, reputation and popularity of individual health enterprises, it continues to contest the current governance model in specialised health care. However, its success in changing the enterprises' proposals and decisions has been modest, and the strategy of restructuring and decommissioning remains an important management tool of the health enterprises. Nevertheless, it has had considerable success in mobilising cultural opposition by framing the cause in the four ways suggested by our findings. The contradictions within the field of health care and hospital services between the institutions of political organisation/public administration on the one hand and the company on the other prove to be at the heart of the resistance and fuel the movement's support and popularity. Furthermore, our study demonstrates that protests against changes in health services and hospital structure go far beyond a single concrete proposal or decision by the health enterprise management, and that they also go beyond health care and health services. The foundation and appeal of the protests seem to lie in popular ideas about localism and democracy. We therefore conclude that the impact of the local hospital movement on hospital governance has been cultural and, to a much lesser extent, substantial and material.

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