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Article information:

To cite this document:
Knut Boge Anjola Aliaj , (2017)," Albania vs. Norway - FM at two university hospitals ", Facilities , Vol. 35 Iss 7/8 pp. -
Permanent link to this document:
http://dx.doi.org/10.1108/F-07-2016-0079

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Albania vs. Norway - FM at two university hospitals

Introduction

Facilities Management (FM) at hospitals takes place in a complex context and extreme environment. Smooth and seamless provision of FM and facilities services matching the hospital's clinical needs is of high importance for the hospitals' ability to carry out their core business. Thus, studies of FM and facilities services at hospitals can be understood as extreme cases and highly relevant objects of study for those who aim for a better understanding of FM and facilities services as such. Findings concerning FM and provision of facilities services at hospitals may also have significant transfer value to many other kinds of organisations.

Medical procedures and treatments at hospital have very much become standardised. Today, there are de facto universal standards for how medical doctors and nurses are supposed to treat particular diseases or sufferings, and these standards are usually based on so-called evidence-based medicine (EBM); i.e. medical treatment based on validated research. One important source for validated medical research is Cochrane Database of Systematic Reviews (CDSR) (Cochrane Library, 2016). The European standard EN15221 (CEN, 2006) and IFMA's (2003) definitions of FM have similarly established principles that have become or are in the process of becoming de facto universal standards for FM and provision of facilities services. There are also universal principles concerning how to achieve and maintain cleanliness, hygiene and food-safety. The hospitals' FM organisations have to work according to these universal principles to facilitate the hospitals' efficiency, cost effectiveness, patient safety, service quality and reputation.

The present research is an explorative, descriptive and comparative case study of FM and food and catering services at an Albanian and a Norwegian university hospital. So far, there are few studies of FM in Albania. There are also few comparative studies of FM at hospitals in different countries.

FM at hospitals

There are several studies of FM and facilities services at hospitals. Many of these studies have taken place in the United Kingdom's (UK) National Health Service (NHS). The NHS was established in 1946. The founding principles were universal access to health services and freedom from charges. The NHS has been subject to numerous reforms (Flynn, 1997). The most comprehensive NHS reforms were a consequence of the so-called New Public Management (NPM). The NPM philosophy diffused from the Anglo Saxon countries to the rest of the world; among others through organisations like OECD, IBRD, IMF and several consulting companies that managed to establish a large market for public sector reforms. The initial strands of NPM reforms were according to Walsh (1995) firstly based on implementation of private sector managerial principles in the public sector, such as Taylorism and emphasis on improved efficiency and cost effectiveness, and secondly implementation of market mechanisms within the public sector. The NHS has been the role model for many other European public health care systems. Norway's current public health care system has very much used the UK's NHS as a blueprint.

Several waves of NPM reforms have transformed the UK's NHS from an integrated almost monolithic hierarchical bureaucracy to a dispersed network of more or less market-based organisations with a purchases-provider split. The NPM reforms also replaced professional autonomy and self-government with general managers hired through performance pay contracts (Hood, 1996). The NHS was one of the first tax-financed public health services to consider and implement FM. FM in the NHS is thus a relevant yardstick for FM in other health care organisations, and this is why studies of the NHS are of relevance for studies of university hospitals in Albania and Norway.

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Price (2004) established a generic facilities classification model, based on technological complexity and risk on the X-axis (low vs. high) and the business impact on the Y-axis (slow or indirect vs. high and fast). Price (2004) used hospitals as a textbook example of organisations with high complexity and risk, and high and fast business impact in case of problems with the facilities. FM is thus a business critical and very essential activity at most hospitals.

"Strategic alignment" of the FM functions and the clinical functions is very important for hospitals aiming at effective and efficient provision of health care services, and poor FM practices can "significantly hinder the delivery" of the hospital's core services (Featherstone and Baldry, 2000). These requirements are there, no matter how the hospitals have chosen to organise FM and provision of facilities services; i.e. in-house, out tasking or outsourcing to one or more external service providers, or hybrid models that combine in-house and external provision.

Rees (1997; 1998) found that FM has penetrated deeper, wider and to a higher managerial level in the NHS than in most other public administrations in the UK. In the late 1990s, the NHS trusts integrated non-core services in FM service divisions headed by senior managers, which became responsible for in-house production and outsourced services (Rees, 1997; 1998). Establishment of integrated FM divisions headed by senior managers was an opportunity for the NHS' facilities managers to "coordinate and package the required portfolio of property, goods and service that best support the organisation's needs" (Payne and Rees, 1999).

One of the main challenges for facilities managers at hospitals is to integrate the FM-organisation with the hospital's clinical teams; there are usually no formal line management relations between the FM-organisation and the clinical teams. Heng et al. (2005) found that "social brokerage"; i.e. occupying a structural position that facilitates "linking pairs of unconnected actors" can provide access to information, expertise and functional support. Thus, all other things equal, facilities managers who have brokerage skills increase their likelihood for succeed as facilities managers. MacDonald et al. (2009) found that successful facilities managers in the NHS have managed to establish good relationships across organisational and professional boundaries, to facilitate cooperation with the clinical teams and the hospital's top-management. Thus, MacDonald et al.'s (2009) findings supported Heng et al.'s (2005) social brokerage hypothesis.

Changed management structures were not the only part of the NHS reforms. One of the keys to "successful facilities delivery", according to Payne and Rees (1999) is specifications of the deliveries through Service Delivery Agreements (SLAs). According to EN15221-1 (CEN 2006), an SLA is an agreement between the client/customer and the service provider on performance, measurement and conditions of services delivery.

Performance Indicators (PIs) and Key Performance Indicators (KPIs) are two of the SLAs' siblings. EN15221-1 (CEN, 2006) defines KPIs as measures that that provides essential information about performance of facility services delivery. KPIs for facilities and facilities services are often multidimensional. Shohet and Lavy (2004) concluded, "FM requires different quantitative and qualitative measures of performance".

Another sibling of SLAs is benchmarking. EN15221-1 defines benchmarking as a process of measuring performance (including price) of facility services and comparing the results internally and/or externally. Benchmarking can also be understood as an approach to organisational learning. The NHS established a Benchmarking Club, and the NHS' top management body, the NHS Executive encouraged introduction of benchmarking as a mean to improve the NHS' services and to achieve the UK government's policy goals about obtaining the world's "best" health care services (Guven-Uslu, 2005). Collaborative process benchmarking of the NHS trust hospitals' catering services, was one of the reforms implemented to establish best practice and to facilitate organisational learning (Akhlaghi, 1997).

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The NHS and the British Medical Association's (BMA) surveys revealed that two of the patients' top ten priorities were FM-issues, namely cleanliness, and hospital food (Miller and May, 2004; May and Pinder, 2008). The NHS has recognised the food's importance, and has launched several initiatives for improvements of the hospitals' food and catering services (May and Pinder, 2008). In 2014, the UK's Department of Health's Hospital Food Standards Panel issued a comprehensive national recommendation for food and drink in the NHS hospitals (Department of Health, 2014). The NHS (2016) has also established SLAs and KPIs for the hospitals' food and catering services. Ahmed et al.'s (2015) study based on value stream mapping of hospital food and catering services indicates a complex and vulnerable but manageable process.

Under nutrition of particularly elderly patients at hospitals is a problem all across Europe (Norman et al., 2008; Donini et al., 2008; Eide et al., 2014). Improvements of the patients' nutritional status can shorten the patients' recovery time. The hospitals' timing of meals, the meal situation, and how the food is served affects the patients' satisfaction of the hospitals' food and catering services (Edwards et al., 2000). Donini et al. (2008) claimed that service quality is not sufficient; the patients also need nutritional correct food to avoid malnutrition. Thus, it is possible to provide nutritional correct food and high quality food services if the hospital's food production and service chain is properly organised and managed. Many hospital patients receive their food from ward kitchens and buffets. Food and catering services at the hospitals' ward kitchens and buffets are thus highly relevant objects of study.

Hypotheses

As mentioned initially, the present research is an explorative, descriptive and comparative case study of FM at an Albanian and a Norwegian university hospital. The reason for choosing university hospitals in Albania and Norway as objects of study is to insure high variation in the explanation factors that can explain the outcomes. Albania is almost a developing country, and Norway is one of Europe's most affluent countries. The Albanians have limited trust in their health care system, while most Norwegians trust their health care system. Both university hospitals have large in-house FM organisations, but the Albanian university hospital has outsourced provision of food and catering services. The present research's main purpose, given the premise about de facto universal standards for medical treatment, FM, cleanliness, hygiene, and food quality and food safety, is therefore to test two hypotheses:

Firstly (H1): Recognition of FM and establishment of a designated FM organisation. The reason for this hypothesis is an assumption about different recognition of FM at the two university hospitals in Albania and Norway.

- H1A: The present research's Albanian university hospital has recognised FM and established a designated FM organisation.
- H1B: The present research's Norwegian university hospital has recognised FM and established a designated FM organisation.

Based on the literature review, H1 makes it possible to derive six empirically testable implications:

- The university hospital's top management has recognised the organisation's complexity and dependence of adequate FM and facilities services.
- The university hospital has established a designated FM organisation.
- A facilities manager (senior manager) heads the university hospital's designated FM organisation.

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- The facilities manager (senior manager) is member of the university hospital's top management team.
- The facilities manager (senior manager) has recognised the university hospital's complexity and the medical services' dependence on adequate FM and facilities services.
- The facilities manager (senior manager) has managed to establish good relations across the university hospital's organisational and professional boundaries.

Secondly (H2): Provision of adequate food and catering services at ward kitchens and buffets. The reason for this hypothesis is an assumption about different provision of food and catering services at the Albanian and the Norwegian university hospital.

- H2A: The present research's Albanian university hospital provides adequate food and catering services at ward kitchens and buffets.
- H2B: The present research's Norwegian university hospital provides adequate food and catering service at ward kitchens and buffets.

Based on the literature review, H2 makes it possible to derive six empirically testable implications:

- There is a national standard for food and nutrition at health care institutions.
- There is a national standard for food safety and hygiene at health care institutions.
- Skilled food and catering staffs carry out the food and catering services at the university hospital's ward kitchens and buffets.
- The university hospital has established SLAs for food and catering service at ward kitchens and buffets.
- The university hospital has established KPIs for food and catering service at ward kitchens and buffets.
- The university hospital has implemented benchmarking of food and catering service at ward kitchens and buffets.

These empirically testable implications derived from the two hypotheses are examined in the results section, and compared and discussed in the discussions section.

Methods

The present research is an exploratory and descriptive comparative case study. King et al. (1994, pp. 55, 56) describe descriptive inference as "the process of understanding an unobserved phenomenon on the basis of a set of observations", and to understand whether the observations actually represent a "typical phenomena or outliers". The present research's analytical model is not a formal but a heuristic device. The idea is that background variables such as history, culture, and political and economic business cycles determine the context for development of FM and provision of food and catering services at ward kitchens and buffets at the Albanian and the Norwegian university hospitals.

Case studies are typically used to understand a phenomenon or class of phenomenon in context, and case studies are based on an experimental logic (Yin, 2009). Case studies also usually aim at

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elucidating one or more phenomenon in a broad population; i.e. "about something larger than the case itself" (Seawright and Gerring, 2008). Case studies are also very useful for making "descriptive inferences, *all other things being equal*", but one problem is that "ceteris is not always paribus" (Gerring, 2004, Gerring's italics).

One of the main issues in case study research – similarly as in most other kinds of research – is selection of cases or units of study; i.e. sampling decisions. The most relevant strategy for case selection given Seawright and Gerring's (2008) study of sampling and analytical strategies is the so-called "Diverse Cases" strategy, because it provides "maximum variance along relevant dimensions". Albania and Norway are in many instances opposites and thereby provide plenty of variance along relevant dimensions. All other things equal, variance in the relevant dimensions; i.e. the explanation factors or independent variables and outcome or dependent variables, improve a study's explanation power. Thus, in the present research the so-called diverse cases approach seems justified.

The present research is based on several methods for data collection; i.e. method triangulation. The Albanian data were collected in 2014, 2015 and 2016. Most Norwegian data were collected in 2015 and 2016, even if data collection at the Norwegian university hospital already began in 2010.

Most data about the Albanian and Norwegian health care systems' configurations stems from literature studies (secondary data). Data about the Albanian and Norwegian university hospitals, hereunder provision of FM and facilities services, have mainly been collected through qualitative interviews and discussions with hospital managers and other employees (primary data), based on informed consent from those involved. The present research is also based on observations at the two university hospitals (primary data). Some data about the university hospitals have been collected through literature studies (secondary data).

In 2015, the Norwegian university hospital's FM department assisted by a third party service provider distributed an online census to the hospital's managers (N = 398) to assess the managers' (i.e. the customers and users') perception of the quality of services provided by the FM department. The hospital managers answered the questions via their own computer. The answers to the questions about service quality had a six item Likert scale ranging from "Disagree completely" (1), "Disagree partly" (2), "Disagree weakly" (3), "Agree weakly" (4), "Agree partly" (5) to "Agree completely" (6), and "Don't know/Not relevant". In 2016, one of the present research's authors got access to depersonalised (secondary) data from this census. The response rate concerning ward kitchens and buffets was 6.5 per cent (N = 26). However, the response rate concerning ward kitchens and buffets was actually far better than the numbers indicate, because the Norwegian university hospital has approximately 15 ward kitchens and patient buffets.

The Albanian survey, was based on a translation of the Norwegian university hospital's 2015 service quality questionnaire, and had a six item Likert scale, ranging from "Disagree completely" (1) to "Agree completely" (6), and "Don't know/Not relevant". During the fall 2015 one of the authors interviewed a convenience sample (primary data) of managers, employees and patients (N = 37) at the Albanian university hospital about ward kitchens and buffets. The author asked the questions and noted the respondents' answers in the questionnaires (structured interviews). During these interviews, the author also made observations.

Data from the Albanian survey and the Norwegian census have been analysed as descriptive statistics with IBM SPSS version 23. However, there is one potential problem when using IBM SPSS to analyse small samples (N < 30) for descriptive statistics. IBM SPSS does not calculate the variance as the sum of squares divided by N, but as the sum of squares divided by (N-1), which is correct for inferential statistics. The standard deviations (SD) calculated by SPSS have to be multiplied with a correction factor, if N < 30 to obtain correct descriptive statistics. This correction factor is according to

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Weinberg and Abramowitz (2015, pp. 80-84) equal to the square root of (N/N-1). In the present research, these corrections are made in those instances where N < 30.

Can we trust the findings in the surveys and census? The Albanian survey was a convenience sample of those managers, employees and patients who were present when the researcher made the interviews and were able and willing to answer the questions. Convenience sampling is a non-probability sampling method, and the representativeness is based on the researcher's judgement about the respondents' representativeness of the population under study (McDaniel and Gates 2010, pp. 343-345). There is also a risk for bias. The Norwegian university hospital's online census was distributed to the hospital's managers. A census does not necessarily provide more accurate data than a sample (McDaniel and Gates, 2010, pp., 326-328). The census data were depersonalised. It was thus not possible to estimate the response rate in the hospital's different departments. Nevertheless, censuses will most likely all other things equal provide more representative and accurate data than convenience samples. None of these data has been collected through probability sampling methods; hence, it is not possible to generalise the present research's findings about food and catering services.

Surveys and censuses also represent a risk for interview effects like "acquiescence" and "social desirability" (Bryman and Bell, 2003). Hellevik (1994) found an increased tendency to "yeasaying" among respondents with low level of education compared to respondents with medium and high education. All other things equal, there is probably a slightly higher risk for yeasaying in the Albanian surveys than in the Norwegian census. One method to control for possible interview effects is to examine the covariation in the respondents' answers. The bivariate correlation coefficient r (Pearson's Rho) is a standardised effect measure that vary between -1 and +1, where 0 indicates no correlation/no effect, and where -1 and +1 indicates perfect negative and positive correlation (Field 2013, pp.66-67, 266-276). Low correlation between service quality and the staffs' skills may indicate yeasaying, because service quality is often considered to be related to the staffs' skills.

Results

This section presents the findings at the Albanian and the Norwegian university hospital concerning recognition of FM and food and catering services at ward kitchens and buffets. The structure is first a presentation of the findings at the Albanian university hospital, and thereafter a presentation of the findings at the Norwegian university hospital.

The Albanian health care system and the Albanian university hospital

The Ministry of Health owns most of Albania's hospitals. There are 51 hospitals in Albania, including 22 smaller hospitals and 20 larger district hospitals with anything from 100 to 400 beds and several specialist hospitals. Albania has a shortage of hospital beds both for long and short-term patients.

The Albanian health care system together with the justice system is considered very corrupted (Aliaj, 2015). According to European Value Survey (EVS) 2008, 46.5 per cent of the Albanian respondents did not have very much confidence in the health care system, and 24.1 per cent of the Albanian respondents did not have any confidence at all in the health care system (N = 1499) (GESIS, 2008a). The similar figures for the Albanian justice system in EVS 2008 were 42.6 and 29.3 per cent (N = 1474) respectively (GESIS, 2008a).

The rate of hospital admissions in Albania is much lower than in most other European countries. One of the reasons for the low admission rate is that poor people in Albania often avoid hospitalisation because they cannot afford under-the-table payments demanded by doctors and other personnel at

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public hospitals. Antoun et al. (2011) claim Albania's Ministry of Finance has attempted to reduce the informal payments by increasing the physicians' compensation. The Albanians also question the public hospitals' inferior services, shortage of medicines and unsanitary environment.

The Albanian Ministry of Health's 2012 performance review of public hospitals among others uncovered poor training concerning staff management, poorly motivated employees that influenced the hospitals' service quality, and lack of maintenance of new equipment that gave poor availability (Aliaj 2015, p. 51). Thus, the ministry's performance review uncovered several managerial and FM issues with potentials for improvements.

Albania is not member of the European Union (EU), but in 2013, Albania became a candidate member. Being a candidate member means the Albanian government has to start a process of adapting Albania to EU's rules and regulations, hereunder regulations for health care institutions.

The government finances the present research's Albanian university hospital, which also has income from the medical services, according to service fees set by the Minister of Health and the Minister of Finance. The Albanian university hospital may also receive financial support from national or foreign donors. However, the Albanian university hospital cannot provide any medical service before the coverage of the costs of medical services have been clarified. In case of an uninsured patient or a patient not covered by the law concerning free hospital services, the patient has to declare her financial capacity. When patients cover the medical expenses themselves, the estimated costs have to be paid in advance, in cash or other forms according to predefined rules. This is one of the reasons why Albania's health care system is considered one of the most unequal in Europe and Asia.

The Albanian university hospital is a National Public Health Institution for treatment and academic research that serves the entire population. The university hospital has a built area of approximately 165,000 square metres, approximately 2300 employees, hereunder almost 1700 medical staff. The hospital treats about 150,000 ambulatory patients and about 200,000 emergencies, and hospitalizes approximately 60,000 patients per year. The Ministry of Health manages the hospital, even if both the Ministry of Health and the Ministry of Education and Science manage the hospital's academic institutional parts.

The Albanian university hospital has an Activity division consisting of four departments; namely Chirurgical, Medical, Neuro-Psychiatric and Paediatric departments. There are also five support divisions, namely Economy, HR and Education, Legal and Public Relations, Investments, and Support Services. In other words, the Albanian university hospital has no designated FM organisation, but the Support Services division have some tasks, functions and responsibilities usually found in FM organisations. The Support Services division has three departments, namely Technical Services, Transport and Supply, and Hospitality and Private Supervision. Most facilities services at the Albanian hospital are provided in house, by unqualified staffs who have been working there for long time. The exception is food and catering services, which in 1996 became outsourced. However, the Hospitality and Private Supervision department in the Support Services division does not have any SLAs or KPIs in place. There are also few and rare supervisions and no written data available.

The Albanian university hospital's heads of divisions always have university degrees, but this is not necessarily the case for lower level managers. Many of those have only general high school diplomas. The Support Services division's director participates in the general director's top management group.

In Albania, the term FM is hardly recognised, but there are some de facto FM practices in relation to some building services (Hard FM), particularly in internal building departments and general service divisions. However, in Albania the term FM is hardly recognised at all concerning soft services (Soft FM) such as cleaning, food and catering, security, etc.

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Food and catering services at ward kitchens and buffets the Albanian university hospital

The Albanian Ministry of Health on behalf of the university hospital establish contracts with the food and catering service providers. The agreements vary from one-year to several year contracts (Aliaj, 2015).

Aliaj's (2015) first-hand observations of provision of food and catering services at three different Albanian public hospitals, hereunder the present research's university hospital, gave reasons to concern: The third party food services providers and not the hospitals' dietician doctor planned the patients' weekly menu. The patients were not served any fruits, even if fruits are considered very important for the patients' health. The served menu was not always according to the planned menu. The hospitals' employees engaged in contract monitoring did not perform quantitative measurements of the food to verify whether the menu delivered contained the necessary calories according to the patients' diagnosis. The food was not always distributed according to the specified schedules, and meals were not always served with correct temperature. The staff who served the meals did not use gloves when they distributed food. The patients were in some cases not permitted to eat their meals in peace and quiet because of medical interventions. Some patients had been asleep when the meals were served, and the staff had not left food for them. Many patients did not trust the hospitals' food service, and consumed food from outside the hospital.

Another observation was several private service providers working at the same hospital (Aliaj, 2015). However, the Albanian model is not several single service providers providing different services, but several single service providers providing similar services such as food and catering at one hospital. The commercial service providers have *not* implemented unified systems. Aliaj (2015, p. 48), also found "there is no Service Level Agreement in place", nor are there any "clearly defined measurement of the service provided" or "any penalties provisions". There are specific vocational educations for cooks in Albania, but the research has not found any formal requirement for a diploma or certificate of completed apprenticeship for employment as hospital cook. The food service contracts' absence of SLAs and other performance indicators makes it very difficult to manage and improve the hospitals' food services. Despite these shortcomings, the food services for the patients are allegedly better than before outsourcing of food and catering services.

Aliaj (2015, p.54) recommended the Regional Health Authority (AHSR) and the National Food Authority (AKU) to audit the Albanian hospitals' food service performance and staff services, to avoid contamination and to maintain food safety. According to Aliaj (2015, p. 55), during the last three years AKU have only - on request from the service provider - performed 7 audits and examinations of physical food samples' chemical and bacteriological characteristics. The average rate has been one control per year, which is very low, and the results of such audits are not available for the public. Aliaj (2015, p.54) also recommended implementation of standards for planning of the hospitals' facilities, training of the medical staff in facilities management, external quality assessment structures and quality improvement procedures.

Albania's Supreme State Audit (SSA) have identified bad nutrition of patients at hospitals, which cases effects such as muscle weakness, limited mobility, delay in healing of wounds, increased side effects of medication, infections, dehydrations, metabolic damage, apathy and depression, etc. Bad nutrition also causes extended hospitalisation, complications, increased staff time and increased number of readmissions (Aliaj, 2015). Hence, the absence of SLAs and KPIs in the Ministry of Health's food service contracts for the hospitals has consequences both for the service provision and for the patients' nutrition status. There is clearly a potential for improvements.

During the fall 2015, one of the authors made a survey to investigate provision of food and catering services at ward kitchens and buffets at the Albanian university hospital (timeliness, quality, service mindedness and skills). This survey was based on a convenience sample (N = 37), of managers (N = 14), employees (N = 14) and patients (N = 9). The instrument was a translation of the Norwegian

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university hospital's 2015 questionnaire with a six item Likert scale ranging from "Disagree completely" (1), to "Agree completely" (6), and "Don't know/Not relevant". The author interviewed the respondents and noted their answers in the questionnaires. The samples are small and not randomised, but the survey may still provide valuable insights about the Albanian university hospital's ward kitchens and buffets.

The Albanian respondents' mean score for timeliness was 4.67 (SD = 1.17, N = 36, 1 "Don't know/Not relevant"). The patients gave a significantly higher mean score on timeliness (5.75, SD = .66, N = 8) than the managers (4.43, SD = 1.12, N = 14) and employees (4.29, SD = 1.03, N = 14) did. The patients seemed to be more satisfied with the third party service providers' timeliness than the managers were and employees were.

The Albanian respondents' mean score for the quality was 4.50 (SD = 1.25, N = 36, 1 missing). The patients gave even here a somewhat higher mean score (4.75, SD = 1.92, N = 8), than managers (4.57, SD = .90, N = 14) and employees (4.29, SD = .96, N = 14) did, but the patients' mean had a very high SD, which indicates significant variations in perceived service quality. Even the managers and particularly the employees' SDs may indicate they are not particularly happy with the third party providers of food and catering services.

The Albanian respondents' mean score concerning the food and catering staff's service mindedness was 5.21 (SD = 1.26, N = 34, 3 "Don't know/Not relevant"). The patients had a slightly lower mean score (5.00, SD = 1.83, N = 6) than employees (5.21, SD = 1.08, N = 14) and managers (5.29, SD = .96, N = 14). The few patient respondents, because of three "Don't know/Not relevant", had high SD and significant variations in their answers. The employees and particularly the managers actually had a more positive impression of the food and catering staffs' service mindedness than the patients had.

The Albanian respondents' mean score concerning the food and catering staff's skills was 5.34 (SD = .97, N = 35, 2 "Don't know/Not relevant"). A closer examination revealed that patients had a somewhat better impression of the food and catering staffs' skills (mean = 5.57, SD = .73, N = 7) than employees (5.29, SD = 1.03, N = 14) and managers (5.29, SD = .96, N = 14). Even these answers seem to be consistent, despite more variation in the managers and the employees' answers compared to the patients' answers. However, two patients', "Don't know/Not relevant" answer may indicate dissatisfaction with the staffs' skills.

If we accept this survey's face value, based on the respondents' subjective perception of the food and catering services at the Albanian university hospital's ward kitchens and buffets, sorting the four questions in descending order according to the grand means, give the order of food and catering staffs' skills (5.34), service mindedness (5.21), timeliness (4.67) and quality (4.50). A similar sorting of the patients' answers give the order of timeliness (5.75), skills (5.57), service mindedness (5.00), and quality (4.75). The managers' answers gave the order of food and caterings staffs' skills (5.29) and service mindedness (5.29), quality (4.57) and timeliness (4.43). The employees' answers gave the order of the food and catering staffs' skills (5.29), service mindedness (5.21), and timeliness (4.29) and quality (4.29). These findings may indicate yeasaying, such as noticed by Hellevik (1994), because the correlation between quality and skills is only 0.549 (p = 0.001, N = 35). The respondents' high rating of skills seems somewhat inconsistent with their low rating of quality. Despite this concern, the findings in the 2015 survey at the Albanian university hospital seems to be somewhat better than Aliaj's (2015) findings at the three Albanian public hospitals. However, the external service provider's food and catering services at the present research's Albanian university hospital's ward kitchens and buffets clearly have a potential for improvements.

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The Norwegian health care system and the Norwegian university hospital

The Norwegian health care system is based on the principles of "universal access, decentralisation and free choice of provider" (Norwegian Medicines Agency, 2016). The 19 counties owned, managed and operated most Norwegian hospitals until 2002 when the government took over the hospitals. According to former Prime Minister Jens Stoltenberg (2016, pp. 181-182), one reason for the government's takeover was the fact that the counties did not have financial muscles to modernise the health care system. The Norwegian government was also probably fed up with county politicians that for decades had used patient queues as levers to increase the government's transfer of tax revenues to the counties. Since 2002, development at Norway's publicly owned hospitals has clearly been inspired by and become rather similar to the UK's NHS.

The Norwegian Ministry of Health has delegated responsibility for ownership and operation of the hospitals to four Regional Health Authorities. Norway has six university hospitals. Two in the South Eastern Regional Health Authority, two in the Western Regional Health Authority, one in the Middle Regional Health Authority, and one in the Northern Regional Health Authority.

The Norwegians differ somewhat from the Albanians concerning confidence in the health care and justice systems. According to EVS 2008, 14.4 per cent of the Norwegian had a great deal of confidence in the health care system, and 60.1 per cent had quite a lot of confidence (N = 1090) (GESIS, 2008b). The similar figures for the justice system was 14.5 per cent great deal of confidence, and 63.1 per cent quite a lot of confidence (N = 1090) (GESIS, 2008b). Thus, most Norwegians have confidence in the health care and justice systems.

The tax system and a mandatory national health insurance, which is a part of the tax system finance Norway's publicly owned hospitals. To establish financial incentives for effective patient treatment, Norway's somatic hospitals receive a 60 percent block grant and 40 percent activity-based financing to the Regional Health Authorities. The patients do not pay any user charges if they are hospitalized, but pay defined user charges if they see their general practitioner (GP) or undergo day surgery at the hospitals (Ringard et al., 2013, p.47-66). Similarly, as in the UK's NHS, the GPs are the gatekeepers to Norway's specialist health care.

In-house FM-departments provide most facilities services and other non-medical services at Norway's publicly owned hospitals. The government and the Regional Health Authorities have established several 'umbrella' FM organisations serving every publicly owned hospital. In 1995, the hospitals' Cooperation for Procurements of Medicines (Legemiddelinnkjøpssamarbeidet (LIS)) was established to coordinate the hospitals' procurements of medicines. In 2002, the Health Regions' Procurement Service (Helseforetakenes innkjøpsservice AS (HINAS)) was established to manage procurements for the four Regional Health Authorities and their hospital trusts. In 2015, The Hospitals' Cooperation for Procurements of Medicines merged with The Health Regions' Procurement Service. In 2014, the government established Hospital Buildings (Sykehusbygg HF) to analyse the Regional Health Authorities and their hospital trusts' need for areas and buildings, disseminate knowledge, advice, and to serve as the hospital trusts' professional builder owner and developer. In 2014, the government also established National ICT (Nasjonal IKT HF), to consolidate, develop, coordinate and standardise the health care organisations' numerous ICT systems (Meld. St. 11 2015-2016, p. 48). Thus, since 2002, when the Norwegian government relieved the counties from the hospitals, and reorganised the hospitals to non-profit hybrid organisations, there have been implemented a number of important FM measures to improve the entire health care system's effectiveness and efficiency.

The present research's Norwegian university hospital has a built area of approximately 270,000 square meters and 9000 employees, and provides health care services to approximately half a million inhabitants. In 2015, the university hospital admitted about 62,500 somatic patients, performed about 28,000 day-case surgeries and 264,000 somatic policlinic consultations. In 2015, the university

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hospital also provided about 63,000 days of treatment for psychiatric patients, in addition to a large number of policlinic consultations.

The Norwegian university hospital consists of six medical divisions or clinics, namely Mental Health, Surgical, Medical, Gynaecology and Obstetrics, Child and Adolescent, and Orthopaedics. The Norwegian university hospital also has two support divisions, namely Technology and Diagnostics, and FM.

The Norwegian university hospital's FM division is responsible for in-house provision of approximately 40 different services and products, ranging from real estate management and building maintenance (various aspects of hard FM), via space management, to soft FM services like cleaning, food and catering, working clothes, bedlinen, laundry, security, parking, logistics and orderly services, etc. The FM division's main departments are Real Estate and Development, Operations and Maintenance, Cleaning and Hygiene, Food and Beverage, Security and Service, and Logistics. Some of the FM division's junior managers have bachelor degrees in Facility and Service Management or in Food and Catering Management. Some of the FM division's department managers are engineers; others have the former two-year Housekeeper or Chef Candidate educations. Many of the FM division's service staffs have certificates of completed apprenticeship in their crafts or trades. This is also the case for some of the FM division's managers. Some of the FM division's managers also have further educations in business administration.

The Norwegian university hospital's FM division is headed by a senior manager (facilities manager), and has an annual budget of approximately 85 million Euros and employs about 630 person-years. This university hospital's facilities manager is a permanent member of the managing director's top management team, together with the heads of the clinics. The facilities manager thus participates in strategic discussions on equal terms with those responsible for the hospital's core activities. According to the facilities manager, this model and in-house provision of FM and facilities services is very much recognition of the hospital's complexity and the clinical activities' dependence of FM and numerous facilities services. The facilities manager describes his task as "to see, translate and deliver", and considers himself facilities manager for the hospital's core activities, not only for the buildings. The FM division's mission is to create an arena for treatment of the patients through provision of seamless services to the hospital's clinical activities, employees and patients. In addition, comes various emergency preparedness measures to safeguard the FM division and the hospital's business continuity in case of possible incidents or states of emergency. Thus, the Norwegian university hospital's FM division and provision of facilities services are deeply integrated with the hospital's core activities. So far, this is the common model at most Norwegian university hospitals.

The Norwegian university hospital's FM division has established informal SLAs and KPIs. These SLAs and KPIs are not legally binding documents, but the users of the FM division's services are familiar with these SLAs and KPIs. Thus, the FM division uses these informal SLAs and KPIs to manage buildings, infrastructures, services and service quality. Even the users of the FM division's services can use the informal SLAs and KPIs as yardsticks when assessing the FM division's services. The Norwegian university hospital has implemented several feedback mechanisms to catch discrepancies concerning patient treatments and/or provision of FM and facilities services.

The Norwegian university hospital's FM division, together with seven other Norwegian hospitals, participates in a national benchmarking and bench-learning program organized by Norwegian Real Estate and Facility Management Network's Hospital group. This benchmarking and bench-learning process follows an annual cycle with data collection in February, a key figure meeting in June, and a bench-learning forum in October. The benchmarking process' cornerstones are the hospitals' SLAs, KPI's, key figures and data from various kinds of surveys and other kinds of service quality measurements. By comparing unit costs and other key figures with the service level, the facilities managers and others get a picture of how efficient each hospital operates, and why some hospitals

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are more cost efficient than others. After the annual bench-learning forum, each hospital usually implements a limited number of process or service improvements.

Food and catering services at ward kitchens and buffets the Norwegian university hospital

The Norwegian university hospital's Food and Beverage department employs approximately 50 persons, included a pool of temporary staffs employed at different departments. The Food and Beverage department's food production is based on the cook-chill principle. The food and Beverage department has one large production kitchen, and approximately fifteen smaller ward kitchens in the clinical units that prepare the food for the patients' buffets, etc. The university hospital's buffet concept has a dining room at each ward, where the patients get their food from a buffet assistant. Nurses serve food at the bed to the most ill patients. However, the increasing numbers of very ill patients have changed the division of labour between the wards' nurses and buffet assistants. The Food and Beverage department has low staff turnover, and it is easy to recruit buffet assistants, but the region has a shortage of skilled cooks.

In 1980, the Nordic Council of Ministers introduced the research-based *Nordic Nutrition Recommendations*. In 2012, these recommendations were updated (Nordic Council of Ministers, 2014). Norway is not member of the European Union (EU), but has since 1994 been a member of the European Economic Area (EEA). One consequence of Norway's membership in EEA is that Norway adopts and implements most of EU's rules and regulations. Norway has successively implemented EU's food safety regulations, hereunder HACCP (Hazard Analysis and Critical Control Point), and these regulations determine food and catering services at hospitals and other health care institutions. Norwegian Food Safety Authority (Mattilsynet) enforces the food safety regulations (Mattilsynet, 2016). Every Norwegian hospital and health care institution also has to work according to the Directorate of Public Health's *National guidelines on preventing and treatment of malnutrition* (Guttormsen et al., 2013).

The Food and Beverage department's SLA are firstly that the patients can choose between two kinds of meals, and secondly that the food comply with the health authorities' established nutrition policy. The Food and Beverage department's manager run an annual survey to monitor the users and patient's satisfaction with the food and catering services.

Eide et al. (2014), who investigated under nutrition among elderly patients at a Norwegian university hospital, found nurses who complained about rigid food service practices that gave limited opportunities to individualise mealtimes and meals to undernourished patients. The nurses also questioned the variation in the food offered, and few opportunities for the patients to have snacks between the meals. Strict time limits for food storing and serving, among others because of the food safety regulations, had the unintended consequence that patients undergoing treatments could miss meals. The nurses also complained about the ordering system for special diets, which they considered far from user friendly. Thus, Eide et al. (2014) found some challenges in Norway that had similarities with some of those Aliaj (2015) had identified at the Albanian university hospital.

The Norwegian university hospital's 2015 FM quality census also included questions about ward kitchens and buffets (timeliness, quality, service mindedness and skills). Even these questions had a six-item Likert scale, ranging from "Disagree completely" (1), to "Agree completely" (6), and "Don't know/Not relevant". Only 26 respondents or 6.5 per cent answered the questions about the ward kitchens and buffets, but the response rate is far better than the numbers indicate, because the university hospital has 15 ward kitchens.

The Norwegian respondents' mean score concerning the ward kitchen and buffets' timeliness was 4.88 (SD = 1.55, N = 26, 1 "Don't know/Not relevant"). These findings indicate the managers were

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reasonably satisfied with the ward kitchen and buffets' timeliness, but the SD indicates variations in the answers. The Norwegian respondents' mean score concerning the ward kitchen and buffets' quality was 4.96 (SD = 1.43, N = 25, 2 "Don't know/Not relevant"). Most managers were reasonably satisfied with the quality, but even here, the SD indicates some variations in the answers. The Norwegian respondents' mean score concerning the ward kitchen and buffet staffs' service mindedness was 5.0 (SD = 1.27, N = 26, 1 "Don't know/Not relevant"). Most managers were reasonably satisfied with the staffs' service mindedness, but even here, there are some variations in the answers. The Norwegian respondents' mean score concerning the ward kitchen and buffet staffs' skills was 4.70 (SD = 1.57, N = 23, 4 "Don't know/Not relevant"). The mean, four "Don't know/Not relevant" and the SD indicates the managers are slightly less satisfied with the food and catering staffs' skills than with timeliness, quality and service mindedness. The Norwegian respondents' answers sorted in descending order according to the questions' means were service mindedness (5.00), quality (4.96), timeliness (4.88) and skills (4.70). There are few indications of yeasaying in the census data about the Norwegian university hospital's ward kitchens and buffets, because the correlation between quality and skills is 0.835 (p = 0.000, N = 23). High positive correlation indicates consistent answers concerning quality and skills.

In a recent study of the Food and Catering section at the Norwegian university hospital, Johansen et al. (2016) found the ordering system for special diets to be far from optimal and in some instances actually an obstacle for cooperation and co-creation between the wards' nurses and food and catering staffs. This finding supported Eide et al.'s (2014) findings. Johansen et al. (2016) also found the Food and Beverage department's SLAs could create conflicts between nurses and food and catering staffs. Even this finding supported Eide et al.'s (2014) findings. Finally, Johansen et al. (2016) found significant differences between the wards' permanent and temporary nurses and food and catering staffs. The wards' permanent nurses and food and catering staffs were more familiar with the norms, rules and the patients' needs, which simplified cooperation between nurses and food and catering staffs at the respective wards. Thus, Johansen et al.'s (2016) findings indicate several possible areas of improvement for the Norwegian university hospital's food and catering services.

Discussion

The present research has examined two hypotheses, namely H1 about the Albanian and the Norwegian university hospitals' recognition of FM and establishment of designated FM organisations and H2 about the two university hospitals' provision of adequate food and catering services at ward kitchens and buffets. The structure is firstly a discussion of H1 about the university hospitals' recognition of FM, secondly a discussion of H2 about the university hospital's provision of food and catering services at ward kitchens and buffets, and finally the conclusions.

H1: Recognition of FM and establishment of designated FM organisations at the Albanian and Norwegian university hospitals

The present research has investigated H1A: The Albanian university hospital has recognised FM and established a designated FM organisation, and H1B: The Norwegian university hospital has recognised FM and established a designated FM organisation. Based on the literature review, six empirically testable implications were derived. Table 1 present these implications together with the findings from the studies of the Albanian and the Norwegian university hospital.

< Insert Table 1 approximately here – Empirical testing of H1A and H1B >

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EVS 2008 (GESIS, 2008a) indicate that Albanians have limited confidence in their health care system, among others because of corruption such as indicated by Antoun et al. (2011) and Aliaj (2015). EVS 2008 (GESIS, 2008b) similarly indicate that Norwegians have high confidence in their health care system.

The Albanian and the Norwegian university hospital have one thing in common, namely that most facilities services are provided in-house. In the Albanian case, there is only weak evidence that the university hospital's top management has recognised the organisation's complexity and dependence of adequate FM and facilities services. In the Norwegian case, there is strong evidence that the university hospital's top management has recognised the organisation's complexity and dependence of adequate FM and facilities services. One of the main reasons for in-house provision of FM and facilities services at the Norwegian university hospital is recognition of the hospital's complexity and the facilities services importance for the hospital's core activities, such as noticed by among others Price (2004). Another reason for in-house provision is strategic alignment of the FM functions and the university hospital's clinical activities, such as suggested by Featherstone and Baldry (2000).

In the Albanian case, there is only weak evidence indicating the university hospital has established a designated FM organisation. The Albanian university hospital has a Support Services division, which perform some FM functions, but the concepts of FM and facilities services are not explicit. In Albania, the term FM is hardly recognised. Most de facto FM activities (Hard FM) in Albania take place in internal building departments and general service divisions. Few Albanians recognise soft services such as cleaning, food and catering as FM. The Norwegian university hospital has an integrated FM division, which provides approximately 40 different services, and the concepts of FM and facilities services are explicitly used. Development of the Norwegian university hospital's FM division is very similar to what happened in the UK's NHS. The Norwegian university hospital's integrated FM division also makes it possible for the facilities manager to "coordinate and package" the portfolio of areas, goods and services (Payne and Rees, 1999). In Norway, the Ministry of Health and the four Health Regions also have established systemic level umbrella FM organisations to serve the public hospitals' needs for procurements, ICT and new hospital buildings.

A director is head of the Albanian university hospital's Support Services division, but this director is not recognised as the Albanian university hospital's facilities manager. A director also heads the Norwegian university hospital's FM division, but this director is recognised as the Norwegian university hospital's facilities manager. Thus, both the Albanian and Norwegian university hospitals have service or FM divisions headed by a senior manager, and this development is very similar to what Rees (1997; 1998) found in the UK's NHS. However, the findings at the Albanian university hospital indicates that being a senior manager is a necessary but not sufficient condition for being recognised as a facilities manager.

In the Albanian case, there is some evidence the director of the university hospital's Support Services division is a member of the hospital's top management team. In the Norwegian case, there is strong evidence the facilities manager and director of the FM division, is an active member of the hospital's top management team together with the heads of the clinics. The Norwegian university hospital's management structure has many similarities with those Rees (1997; 1998) found implemented in the UK's NHS during the 1990s. The findings in the Albanian case indicates that being head of the Support Services division and member of the hospital's top management team is not necessarily a panacea concerning the top management and the staffs' recognition of FM.

However, there is one important difference. None of the managers in the Albanian university hospital's Support Services division has FM educations. Many managers in the Norwegian university hospital's FM division have higher educations in FM or related disciplines. In the Albanian case, there

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is only weak evidence that the university hospital's director of the Support Services division has recognised the university hospital's complexity and the medical services' dependence on adequate FM and facilities services. In the Norwegian case, there is strong evidence that the facilities manager has recognised the university hospital's complexity and the medical services' dependence on adequate FM and facilities services, such as noticed by among others Featherstone and Baldry (2000), Payne and Rees (1999) and Price (2004).

In the Albanian case, there is only weak evidence that the university hospital's director of the Support Services division has managed to establish good relations across organisational and professional boundaries. In the Norwegian case, there is strong evidence that the facilities manager has managed to establish good relations across the university hospital's organisational and professional boundaries, in order to promote FM and to facilitate the hospital's core activities. The Norwegian university hospital's facilities manager obviously have strong brokerage skills, such as described by Heng et al. (2005). The Norwegian university hospital's facilities manager's development of good relationships across organisational and professional boundaries is very similar to what MacDonald et al. (2009) found among successful facilities managers in the UK's NHS.

Today, there are more or less de facto universal standards for FM such as EN 15221 (CEN, 2006) and IFMA's (2003) definition of FM, but the study of the Albanian and the Norwegian university hospital have shown there are different knowledge and different interpretations of such de facto universal standards. Thus, there is only limited support for H1A that the present research's Albanian university hospital has recognised FM and established a designated FM organisation, but there is strong support for H1B that the present research's Norwegian university hospital has recognised FM and established a designated FM organisation. All other things equal, the Norwegian university hospital's organisational measures concerning recognition of FM and establishment of a designated FM organisation appears to be significantly more robust than the organisational measures at the Albanian university hospital. The Albanian university hospital's Support Service division is currently a far less developed service provider than the Norwegian university hospital's FM division. The Norwegian university hospital's FM division almost operates like a commercial third party service provider. The Albanian university hospital's provision of facilities services seems only partially integrated with the hospital's core activities. The Norwegian university hospital's FM division and its provision of facilities services is deeply integrated with the hospital's core activities.

One important measure if the Albanian Ministry of Health would like to improve the Albanians' trust in their public health care system is to establish a program for development of FM at the hospitals. Development of or employment of skilled facilities managers all other things equal, facilities improved FM at hospitals, and improved FM at hospitals will all other things equal facilitate improved medical treatment of patients. This is evident in the UK's NHS and at the present research's Norwegian university hospital.

H2: Provision of adequate food and catering services at the Albanian and Norwegian university hospitals' wards kitchens and buffets

The present research has also investigated H2A: The Albanian university hospital provides adequate food and catering services at ward kitchens and buffets, and H2B: The Norwegian university hospital provides adequate food and catering services at ward kitchens and buffets. Based on the literature review, six empirically testable implications were derived. Table 2 presents these implications together with the findings from the studies of the Albanian and the Norwegian university hospital.

< Insert Table 2 approximately here – Empirical testing of H2A and H2B >

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Hospital food is one of the UK NHS patients' top ten priorities, according to Miller and May (2004) and May and Pinder (2008). There are reasons to assume that even Albanian and Norwegian patients prize hospital food.

In the Albanian case, there is only weak evidence concerning national standards for food and nutrition at health care institutions. Aliaj's (2015) findings indicate a somewhat lenient implementation of such standards. In the Norwegian case, there is strong evidence, because the Nordic and Norwegian authorities have issued several guidelines concerning food and nutrition at health care institutions, as well as national guidelines for prevention and treatment of malnutrition of patients.

In the Albanian case, there is only weak evidence concerning a national standard for food safety and hygiene at health care institutions. Aliaj's (2015) findings also indicate lenient enforcement of such regulations. Norway is member of EEA, and Norway has approved and implemented EU's rules and regulations concerning food safety and hygiene, hereunder the HACCP philosophy, similarly as for instance in the UK's NHS (2016; Departments of Health, 2014). The Norwegian university hospital definitely has a food safety and hygiene regime, and the Norwegian authorities have implemented strict enforcement of food safety and hygiene regulations in health care institutions.

The Albanian university hospital has outsourced food and catering services to a commercial third party service provider. The Albanian food and catering staffs' formal qualifications have not been clarified. At the Norwegian university hospital, the FM division's Food and Beverage department provides food and catering services. The Food and Beverage department's cooks and many other staffs working with food and catering services at the Norwegian university hospital have vocational education and certificates of completed apprenticeship, either as restaurant or as institutional cooks. There were some differences between the mean scores at the 2015 survey at the Albanian university hospital and the 2015 census at the Norwegian university hospital. The Albanian respondents seemed to be more satisfied with the staffs' service mindedness and skills than the Norwegian respondents were, but the food quality at the Norwegian university hospital seemed to be somewhat better than at the Albanian university hospital. Aliaj (2015) found that food and catering services at the Albanian university hospital have a significant potential for improvements. Eide et al. (2014) and Johansen et al. (2016) similarly found areas for potential improvements of the Norwegian university hospital's food and catering services, such as adjustments of the routines and procedures, and improved cooperation between nurses and food and catering staffs. Food and catering at hospitals is obviously a far more complex service than for instance daily cleaning at hospitals. The food and catering services are highly dependent of a food service chain that has to function flawlessly from raw materials to meals consumed by the individual patients.

The Albanian university hospital has not established SLAs or KPIs for food and catering services at ward kitchens and buffets, even if these services have been outsourced. The Norwegian university hospital's FM division has established informal SLAs and KPIs for food and catering services at ward kitchens and buffets, and these SLAs and KPIs have been communicated to the FM division's customers and end-users. The Norwegian university hospital's implementation of SLAs and KPIs is very much in line with the development in the UK's NHS during the 1990s, described by among others Payne and Rees (1999), but Johansen et al. (2016) found that adjustments of the Norwegian university hospital's Food and Beverage department's SLA could improve the food and catering services.

The Albanian university hospital has not implemented benchmarking of food and catering services at ward kitchens and buffets. The Norwegian university hospital's FM division has both implemented benchmarking of food and catering services at ward kitchens and buffets, and participates in a

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national benchmarking and bench-leaning network for hospitals. The Norwegian university hospital's FM division uses the benchmarking process to organisational learning and development, similarly as Akhlaghi (1997) and Guven-Uslu (2005) found in the UK's NHS.

Today, there are also more or less de facto universal standards for food quality and food safety. Ahmed et al. (2015) indicate that food and catering services at hospitals is a complex but manageable process. However, the study of the Albanian and Norwegian university hospital has shown there are different interpretations of food quality and food safety. Hence, there is limited support for H2A that the present research's Albanian university hospital provides adequate food and catering services at ward kitchens and buffets, but there is somewhat stronger support for H2B that the present research's Norwegian university hospital provides adequate food and catering services at ward kitchens and buffets. All other things equal, the Norwegian university hospital's provision of food and catering services at ward kitchens and buffets appears to be far more robust than the Albanian university hospital's provision of food and catering services at ward kitchens and buffets. However, both Eide et al. (2014) and Johansen et al. (2016) indicate several areas for possible improvements of the food and catering services at the Norwegian university hospital, particularly adjustment of the SLA and improved cooperation between nurses and food and catering staffs. Cooperation between nurses and food and catering staffs seems to be one of the vital parameters for the food and catering services' quality at ward kitchens and buffets.

One of the lowest hanging fruits, if the Albanian Ministry of Health would like to improve the country's hospitals significantly through introduction of FM, is inclusion of SLAs and KPIs in the request for tender when they announce new food and catering contracts to hospitals or if renegotiations of existing contracts. Another low hanging fruit if the Albanian Ministry of Health would like to improve the hospitals' food and catering services is to introduce standardised routines and procedures for the different external service providers serving the Albanian hospitals, hereunder requirements for training and education of the staffs. Standardised routines and procedures will be particularly beneficial for the hospitals, where the staff in some instances have to interact with different service providers. Standardised routines and procedures also simplify change of service providers when food and catering contracts expire. A third low hanging fruit, if the Albanian Ministry of Health would like to improve the hospital's food and catering services, is to mobilise the Regional Health Authorities (AHSR) and the National Food Authority (AKU) to audit the Albanian hospitals' food service performance and staff services, to avoid contamination and to maintain food safety.

Conclusions

The present research is an explorative, descriptive and comparative case study of FM at an Albanian and a Norwegian university hospital. Today, there are more or less de facto universal standards for medical treatment, FM, cleanliness, hygiene, and food quality and food safety. The reason for choosing university hospitals in Albania and Norway as cases is to insure high variation in the explanation factors that can explain the outcomes. Albania is almost a developing country, and Norway is one of Europe's most affluent countries. The Albanians have limited trust in their health care system, while most Norwegians trust their health care system. Both university hospitals have large in-house FM organisations, but the Albanian university hospital has outsourced provision of food and catering services.

The present research's main purpose, given the premise about de facto universal standards for medical treatment, FM, cleanliness, hygiene, and food quality and food safety, was therefore to test two hypotheses:

H1: The present research's Albanian/Norwegian university hospital has recognised FM and established a designated FM organisation.

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H2: The present research's Albanian/Norwegian university hospital provides adequate food and catering services at ward kitchens and buffets.

Empirical testing of the first hypothesis only gave limited support for H1A that the present research's Albanian university hospital has recognised FM and established a designated FM organisation, but strong support for H1B that the present research's Norwegian university hospital has recognised FM and established a designated FM organisation. The Albanian university's Support Service division is currently a far less developed service provider than the Norwegian university hospital's FM division. The Albanian university hospital's provision of facilities services seems only partially integrated with the hospital's core activities, while the Norwegian university hospital's FM division and its provision of facilities services is deeply integrated with the hospital's core activities.

One important measure if the Albanian Ministry of Health would like to improve the Albanians' trust in their public health care system is to establish a program for development of FM at the hospitals. Development of or employment of skilled facilities managers all other things equal, facilitates improved FM at hospitals, and improved FM will all other things equal facilitate improved medical treatment of patients. This is evident both in the UK's NHS and at the present research's Norwegian university hospital.

Empirical testing of the second hypothesis only provided only limited support for H2A that the present research's Albanian university hospital provides adequate food and catering services at ward kitchens and buffets, but there is somewhat stronger support for H2B that the present research's Norwegian university hospital provides adequate food and catering services at ward kitchens and buffets. All other things equal, the Norwegian university hospital's provision of food and catering services at ward kitchens and buffets appears to be far more robust than the Albanian university hospital's provision of food and catering services at ward kitchens and buffets. However, both the Albanian and the Norwegian university hospital have potentials for improvements of the food and catering services at ward kitchens and buffets. The present research's findings indicate that food production and service chains at hospitals are complex and vulnerable, and no such chains are stronger than the weakest link.

The Albanian Ministry of Health can improve the hospitals' food and catering services significantly though implementation of FM-measures. One measure is inclusion of SLAs and KPIs in the request for tender when they announce new food and catering contracts to hospitals or if renegotiations of existing contracts. Another measure is implementation of standardised routines and procedures for the external service providers serving the Albanian hospitals, hereunder requirements for training and education of staffs. A third measure is to mobilise the Regional Health Authorities (AHSR) and the National Food Authority (AKU) to audit the Albanian hospitals' food service performance and staff services, to avoid contamination and to maintain food safety. Adjustments of the Norwegian university hospital' SLA for the Food and Beverage department and improved cooperation between nurses and food and catering staffs at ward kitchens and buffets would all other things equal improve the hospital's food and catering services.

Finally, further research is needed. The present research is an exploratory and descriptive comparative case study. Large N studies should be carried out both in Albania, Norway and preferably also in other countries to corroborate and develop the findings.

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Table 1: Empirical testing of H1A and H1B about recognition of FM and establishment of designated FM organisations at the Albanian and Norwegian university hospitals

Implication	The Albanian university hospital	The Norwegian university hospital
The university hospital's top management has recognised the organisation's complexity and dependence of adequate FM and facilities services	Weak evidence	Strong evidence
The university hospital has established a designated FM organisation	Weak evidence	Strong evidence
A facilities manager (senior manager) heads the university hospital's designated FM organisation	Some evidence	Strong evidence
The facilities manager (senior manager) is member of the university hospital's top management team	Some evidence	Strong evidence
The facilities manager (senior manager) has recognised the university hospital's complexity and the medical services' dependence on adequate FM and facilities services	Weak evidence	Strong evidence
The facilities manager (senior manager) has managed to establish good relations across the university hospital's organisational and professional boundaries	Weak evidence	Strong evidence

Table 2: Empirical testing of H2A and H2B about provision of adequate food and catering services at the Albanian and the Norwegian university hospitals' ward kitchens and buffets

Implication	The Albanian university hospital	The Norwegian university hospital
There is a national standard for food and nutrition at health care institutions	Weak evidence	Strong evidence
There is a national standard for food safety and hygiene at health care institutions	Weak evidence	Strong evidence
Skilled food and catering staffs provide food and catering services at the university hospital's ward kitchens and buffets.	Some evidence	Some evidence
The university hospital has established SLAs for food and catering service at ward kitchens and buffets	No	Yes
The university hospital has established KPIs for food and catering service at ward kitchens and buffets	No	Yes
The university hospital has implemented benchmarking of food and catering service at ward kitchens and buffets	No	Yes

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