The Decentralized Path Challenged? Nordic Health Care Reforms in Comparison

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Preface

This paper is written as part of the research project «Autonomy, Transparency and Management – Three Reform Programs in Health Care» (ATMhealth) at the Stein Rokkan Centre for Social Research.

The aim of ATMhealth is to study such processes of reform and change within the Norwegian health care sector, make comparisons with Sweden, Denmark and other countries, and estimate the consequences of such reforms. Three research areas are emphasized:

1) AUTONOMY. The ambition to establish autonomous organizational units, with a focus on the health enterprise.
2) TRANSPARENCY. The dynamics involved in the strive for transparency, exemplified by the introduction of still more detailed instruments for monitoring of performance and quality, as well as patient's rights to choose and be informed.
3) MANAGEMENT. To establish a more professional and distinct managerial role at all levels is a major ambition for most of the recent reform programs.

A comparative research design is employed – regional, cross-national and global – in order to analyze the relationship between reform activities, organizational changes and service provision. The aims are to:

- Generate research on the preconditions for change in health care by the means of comparative research
- General competence development in organization and management of health care
- assist the health institutions in their efforts to improve service delivery and create more innovative structures for organization and management.

The funding for ATMhealth comes from the Norwegian Research Council and more specifically FIFOS, Research fund for innovation and renewal in the public sector. The purpose of this fund is to create a concerted, multidisciplinary, long-term research effort, in order to encourage organizational changes and innovation in the public sector, and create the common solutions for the public sector of the future.

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More information about ATMhealth at:
http://www.rokkansenteret.uib.no/vr/rokkan/ATM/index.html

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Abstract

In this paper we present alternatives for describing and explaining the developments of Nordic health care in general and hospitals in particular. The backdrop is the Norwegian hospital reform of 2002, a reform that seems to part with predominant conceptions of health care as a local political responsibility. Although Norway, Sweden and Denmark appear to have been on similar pathways with a history of relatively decentralized and welfare-oriented health care systems, there are differences among them that should not be overlooked. The idea is to look at how slightly different development dynamics and actor constellations may produce different results, e.g. as a consequence of reforms. One question raised is whether current development patterns signify a break with the Nordic decentralized path in healthcare organization. We argue that it is necessary to understand how the decentralized path was created in each case in order to understand the dilemmas involved in the contemporary governances structures, with a possible trend towards the unmaking of the traditional model of decentralized welfare provision. We focus on the emergence of neo-liberal ideas such as purchaser-provider models, extended patients' choice, and activity-based funding, and why such models and experiments gained a stronger impact in Sweden than in Norway and Denmark. Norway's reform is a delayed reform, but it is also a reform pointing in a new direction. It was delayed in the sense that much of what is now introduced has been introduced previously in other countries, particularly in Sweden. The reform is also innovative, however, due to its emphasis on state ownership, and it thus represents a challenge to the Nordic decentralized model of health care. Denmark's uniqueness consists in not having undertaken any major reform yet, although healthcare has become an increasingly contested topic in Denmark, and something may be about to happen. Concluding that reform dynamics has played out somewhat differently in each case, we discuss the prospects of an end of the decentralized political-professional regimes. The emerging regime, exemplified by Norway, may not accurately be described as a combination of 'managers and markets' (a term used to characterize the situation in the United States), but rather as a regime of managers and state enterprises that compete with each other under public-professional stewardship.

Sammendrag

Temaet for artikkelen er helsereformer i Norden. Bakgrunnen er den norske sykehusreformen i 2002, en reform som tar farvel med ideen om at sykehusvesenet skal være et regionalt politisk ansvar. Spørsmålet som stilles er om denne reformen representerer et brudd med en veletablert nordisk tradisjon for desentralisert styring, og om forklaringen må søkes i de særegne forhold som preger Norge, eller om det dreier seg om mer allmenne tendenser som også gjør seg gjeldende i Sverige og Danmark. Sykehusstrukturen er ikke bare et resultat av statlig planlegging, men en konsekvens av en lang historisk utvikling, med et mangfold av lokale initiativer fra frivillige organisasjoner, kommuner og individuelle entreprenører. I perioden 1970–2000 var det imidlertid en utvikling i retning av at sykehusene ble regionale og politisk styrte prosjekter i alle tre land. Det utviklet seg etter hvert en dragkamp knyttet til om det var den politiske, medisinske eller bedriftsmessige logikken som skulle være styrende for utviklingen av helsetjenestetilbudet. I tråd med tendensen som beskrives som «New Public Management», kom bedriftstankegangen etter hvert på offensiven. Overgangen til en bedriftsforståelse kom tidligst og klarest i Sverige fra 1980-tallet og utover, mens det kan virke som om den lokale og medisinske forståelsen av sykehuset har vært mer seiglivet i Danmark og Norge. Inntil 2002 ligner Danmark mer på Norge enn Sverige med hensyn til reformtempo, ikke minst når det gjelder innføringen av tiltak i retning av bestiller-utfører-modeller og bedriftsorienterte modeller for styring av helsevesenet. Den norske reformen i 2002 representerer et brudd med det tidligere desentraliserte regimet, og tilsvarende strukturendringer er på vei i de andre nordiske land, selv om det ikke virker som man i Sverige og Danmark vil satse like mye på direkte statlig styring. Samlet sett må man kunne si at staten står sterkere enn noensinne i den nye styringsordningen i nordiske sykehus, noe som er et resultat av at helsesektoren har fått økt betydning, både som andel av statens totale virksomhet og som politisk tema. I den nye modellen for styring er det imidlertid et mål at sykehusene og avdelingene skal være selvstyrte enheter som kan styres «på avstand». Dette skal blant annet skje gjennom å utvikle et system for planlagt konkurranse, f.eks. gjennom innsatsstyrt finansiering og belønning i henhold til effektivitet, pasienttilstrømning og kvalitetsmål. Kanskje er det «kvasimarkedet» som best beskriver den nye tilnærmingen til sykehussektoren, delvis på bekostning av en utbredt forestilling om at den nordiske modellen for organisering av helsetjenestene er offentlig, desentralisert og demokratisk.

Introduction

Hospital reforms have become an epidemic.[1] There is a steady increase in the number of transnational organizations and agencies involved in making diagnosis and suggest solutions for hospitals and health systems.[2] Reform is now the watchword not only for the OECD and the World Bank, but also UNICEF and the World Health Organization (WHO).[3] Some of the work undertaken by such agencies and research groups is to classify different systems of hospitals and welfare.[4] Researchers taking an interest in the historical development of welfare systems have traditionally undertaken a similar task.[5] They started out with making a distinction between the state-centered systems, the so-called Beveridge systems – including the UK and the Scandinavian countries – on the one hand, and the continental Bismarckian social insurance-based systems on the other. There was also a need to distinguish between the Scandinavian decentralized approach and the more centralized welfare state in the UK, however. Accordingly, in the case of hospital systems it has become normal to distinguish between integrated single-payer state-funded systems and systems where there are several funding agencies, and also among the integrated systems depending on whether there is a great deal of autonomy and decentralization in the provision of hospital services. The Nordic countries belong to a «family» of countries classified as single-payer decentralized systems, whereas the USA is at the other end of the spectrum with corporate actors involved both in the funding and provision of health care. As soon as there is classification and comparison, however, a discussion about prospects for convergence between systems develops. In the case of hospital systems, it has been suggested that all countries are now moving towards a model of managed competition, although having different points of departure.[6] Others, however, think that one should not underestimate the social embeddedness of the various systems, and that it is more likely that there will be parallel processes of convergence and divergence.[7]

It is notable in such a perspective that Norway, in January 2002, took a step away from the so-called decentralized Nordic model by re-centralizing control of all hospitals from the counties into the hands of the national government. Committees with a mandate to consider structural reforms have also been set up in Sweden and Denmark.

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[1] Stambolovic 2003.

[2] McPake 2002, Lee and Goodman 2002.

[3] Saltman and Figueras 1997, Or 2002, Preker et al. 2003.

[4] Saltman and Figueras 1997.

[5] Abrahamson 1999, Esping-Andersen 1990.

[6] Ham 1997, in McPake 2003:121.

[7] Saltman 1997, Preker et al. 2003.

Steps are likely to be taken in this direction also in these two countries, at least towards larger regional units as owners, and (in Sweden) towards more state involvement in highly specialized health care. [8] This paper will take its point of departure from these recent events and discuss how they fit into a longer development pattern in Scandinavian health care.

The critical date for the Norwegian hospital reform was January 1st 2002, when all hospitals were transferred from the counties into the hands of 5 regional health enterprises owned by the national government. The hospitals were re-structured from public entities controlled by the state into semi-independently managed public firms. The idea was that the hospitals should now be subject to considerably less managerial intervention from local and central administrators and politicians, and act more like private enterprises. However, the hospitals still cannot go bankrupt and they are owned by the state, so perhaps the idea that they should act as enterprises still is a little bit of fiction.[9] Health policy issues, including the question of whether hospitals should be merged and centralized, are still hotly debated, and the MPs and the government have the possibility to intervene if there is a majority in parliament or if the health minister wants to do so. So, there is a possibility, and perhaps also a strong temptation, for politicians that want to intervene into the hospital system to do so, and thus for the regional and local managers to be constrained from taking the autonomous role prescribed for them in the reform documents.

The questions that will be discussed in this paper are: To what extent does the recent «big-bang-reform» in Norwegian health care and similar, although earlier, still more incremental development patterns in the neighboring countries represent a break with the idea of hospitals as public administration and the Nordic tradition of decentralized healthcare provision? Do we experience a trend in the governance of healthcare towards managed competition, a regime of «managers and markets» as observed in the research by Scott and his associates (2000)? Do social embeddedness and historical inertia matter, and in what way?

There are several ways to go about when trying to identify parallel and divergent development trends. One approach is to concentrate on changes in technologies and socio-economic infrastructure, such as new treatment methods, organizational infrastructure, increase in private providers etc. Another is to focus more on changes that take place on a cognitive and symbolic level. For instance, in the case of privatization, Sahlin-Andersson argues that it does not matter that much who is the owner and how much competition there actually is in the system, if the actors are tuned in to a certain way of acting and thinking.[10] Global models of conceptualizing and

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[8] Vrangbæk 2003, Strukturkommissionen 2004 (Denmark), Socialdepartementet 2003. The Swedish parliament has also set up a commission with the aim to suggest structural adjustments in the relationship between the state, counties and the municipalities. A trade union report (LO-utredning) has suggested that state ownership of hospitals may be necessary also in Swedish health care (Fransson and Wennemo 2003a, 2003b), but a more frequently heard suggestion is to create larger counties.

[9] Sahlin-Andersson 2003.

[10] Sahlin Andersson 2003.

labeling health care services, such as «patient-as-customer», managed care etc. may be spreading fast, and may affect the institutional logic of the organizational field as a whole.[11] If the last approach is used, then there certainly are indications that the new local health enterprises in Norway, although taken over by the state, take their role as «private actors» seriously, and similarly that privatized actors like St.Görans in Stockholm act as if they were public actors. It is thus useful to keep an open eye to both the cognitive and cultural issues as well as long-term structural trends. It does matter how the actors actually experience the situation.

Scott et al (2000) describe specific combinations of social actors, belief systems, and governance structures, which come into existence during the history of an organizational field, in their case the field of hospitals in the San Francisco Bay Area. One may get to the point of identifying specific eras in an organizational field by asking how preferred identities differ across time and space and how they are transformed at critical junctures. Such shifts occur as a consequence of changes in populations of organizations, belief-patterns and governance mechanisms. The healthcare system displays a complex pattern of interactions, which Scott has approached within a framework of three dimensions: First, one can take into account the «institutional logics» that participants in the field carry, composed of cognitive maps and belief systems. These logics guide and give meaning to activities and actions, and thus influence behavior and how behavior is interpreted. Second, there are «institutional actors», that can be understood as being carriers and creators of institutional logics. The third dimension includes «governance systems». These are composed of some combination of public and private actors employing both regulatory and normative controls over the activities conducted within that field.[12] In combination, these three dimensions create a frame for understanding developments over time that includes changes in the ideas that characterize a field, the «players» that act within the field according to these logics, and the political structures that regulate or influence behavior and development. This relates to the issue of periodization, as the ways in which healthcare is developed and governed change over time. Based on their study of the Bay area, Scott and his colleagues identified three institutional epochs in American healthcare.[13] A short overview of these periods may be appropriate, so as to illustrate how the dimensions listed above can be combined in different ways.

The first epoch, from the early decades of the 20th Century to 1964, was *the era of Professional Dominance*. During this period physicians were able to develop and sustain a strong position based on their professional associations and by insisting on the overriding value of the physician-patient relation. Professional staff structures were autonomous from administrative hospital management. The predominant institutional

[11] This argument is confirmed by a comparison between hospitals under different governance regimes in Sweden (public administration and quasi-markets), which shows that there is a shift towards increased cost consciousness and entrepreneurial behavior in both cases (Aidemark and Lindkvist 2003).

[12] Scott et al. 2000: 20–21.

[13] The Bay area has a population of 6,7 million in 2000, compared to Norway with its 4.4 million, Sweden with 8,9 and Denmark 5.3 million (18,6 in total).

logic was to build local healthcare institutions based on local demand. Hospitals were virtually the only type of provider of healthcare services. The federal government was on the periphery of healthcare delivery, since most proposals for national health insurance were defeated.

The second epoch, from 1965–1981, was *the era of Federal Involvement*. In combination, the Medicare act as well as the Medicaid acts became landmark legislation strengthening the role of the federal authorities and giving dramatic expression to the new institutional logic of providing «equal access to care» for all citizens. The federal government thus became a more central actor, pushing the physicians and their organizations into the background for a while. The profession also became more differentiated due to specialization, and the logic of equal access was combined with an increased pressure to keep costs down. A number of «new» hybrid healthcare delivery forms appeared, and these would later take over as the predominant organizations within the field of healthcare and challenge the dominant position of the traditional hospitals.

The third epoch was *the era of Managers and Markets*, and this has been under evolution since 1983. There was a gradual decline in public ownership of healthcare facilities. Although the most traditional forms, such as hospitals, tend to remain non-profit, there are also newer forms for organizing that are primarily for-profit. An increasing number of healthcare organizations are owned by and operated as sub-units of corporations, and the health managers, frequently educated in a business school rather than in a department of public health, have became more predominant actors. While the logic of health care quality is espoused, the logic of equal access has become much less salient. A significant proportion of the population lacks adequate health insurance. Efficiency and cost-containment have become important new values; and governmental policies have shifted toward deregulation, market forces and large corporate groups.[14]

It may be of interest to export such a framework to analyze changes in Norwegian and Nordic healthcare. We are not at a stage in our research where it is possible to aim at a similar systematic mapping of organizational populations, identities and governance forms, but think that we may use the categories and periodization developed by Scott et al as a background for a historical narrative based on historical sources. It has been argued that fairly similar patterns of development are taking place on a Nordic and perhaps also worldwide basis, including both a more management/market-oriented approach and increasing governmental involvement.[15] When comparing this sequence of development with the Nordic and European scene, however, important differences in institutional context have to be noted. In the Nordic countries, the health service is a public matter. In contrast to the US healthcare system, the Nordic systems are built on the principle of universality. This means that all inhabitants shall have the same access to services, independent of social status, location and income. Another important feature of the Nordic health care systems is the predominance of tax-financed public provision. As there is no premium-based financing, there is only a minor connection (limited to out-of-pocket payments, particularly in Norway and Sweden) between

[14] Scott et al. 2000.

[15] Østergren and Sahlin-Andersson 1998:21, Sahlin-Andersson 2003, Freeman and Moran 2000.

individual health risks and costs. Because of this system of financing, voluntary health insurance has not, until recently, been a relevant alternative, as in the United States. The most urgent problem facing the Nordic health care system in the past decade has been cost increases along with the insufficient ability of both general and psychiatric hospitals to absorb patient inflows. Long waiting-lists for non-emergency treatment are considered unacceptable both by patients, politicians and health authorities, and this problem has led to the introduction of quasi-market mechanisms, such as waiting list guarantees, patient rights to free choice of hospitals and activity-based funding.

The Norwegian reform story before 1970: The welfare communes

On the background of this note about differences in institutional context, let us bring in an element that is not often mentioned in recent discussions about health reforms and the relationship between public and private roles in healthcare. It was not the state or the political parties as such that were the entrepreneurs behind the development of Norwegian hospitals, but rather a broader group of institutional welfare entrepreneurs; voluntary organizations, counties, communes and even a few firms. For instance it was reported in 1976, that the 5 broad welfare and social organizations in Norway organized almost ¼ of the Norwegian population, that they had 2920 local membership groups, and organizational boards at a local, regional and national level. Approximately 20 per cent of hospital beds were still under private ownership, although the counties and the state had started to take over or integrate private institutions into their plans as a consequence of the new law that was introduced in 1970.[16] Most of the hospitals that exist today were built between 1900 and 1930, the foundations for the current structure was largely developed between 1920 and 1930 when there was built altogether 84 hospitals.[17] These hospitals had a large degree of autonomy, since the state neither had the mandate to control them nor any major ambition to run them.

It is, from such a perspective, perhaps not quite right to say that the Norwegian system was a «command-and-control-system,» although the voices that demanded a stricter control regime were certainly present in the post-war political debate. There was also a great deal of trust towards the health authorities from below; Berg and Haug have argued that the logic of hospital clinics was extended into the state, not the opposite.[18] Karl Evang, the major figure in the post-war development of Norwegian health services, stated as late as in 1970 that the health authorities had come to underline ever more the decentralized approach in the administration of hospitals, this was a consequence of

[16] Sosialdepartmentet 1976.

[17] Grønlie 1987, Sveen 1979, Hansen 2001.

[18] Berg and Haug 1996.

«the bitter experience that the state is not suited to actually run hospitals».[19] A hospital law was introduced in 1970, and this was the first time that the Norwegian parliament had a general debate about the Norwegian hospital system. The major instrument for creating equity was the demand put to the counties that they developed plans for hospital development that had to be approved by the state. The Norwegian counties did not have the powers to acquire their own funds by increasing local tax rates, and the role as the sole provider of funding gave the state a strong position in the negotiations with the counties about hospitals. Certainly the counties depended on state approval in order to implement their plans, but the county council was also democratically elected and there were limits to how far the state could intervene into county planning. A conflict developed in the case of Sogn og Fjordane, a county with a disperse population and no central hospital at the time. The state wanted to build a new central hospital and close down several others, whereas the local politicians wanted to keep the traditional structure. The conflict ended with sort of a compromise in 1975, i.e. a new hospital was set up while they also kept the others. Since then it has been difficult for the state to insist on a strong centralization in the Norwegian hospital system. There has been a trend towards regionalization in hospital planning, however, and the regions that were first set up in 1975 and made mandatory, as instruments for planning in 1999, became the basis for the health enterprises that were set up in 2002.

From professional-political regime to competitive regime

In hindsight it looks as if the regime that existed between 1970 and 2002 was quite unstable, the conflicts between professions, districts, administrators and politicians, and local and central health authorities were recurrently displayed in the media, and the terms «omkamp» («rematch») and «blame-game» (or «black man») was repeatedly used to describe the situation. Health politics was a frequently debated topic in Parliament as well as in local politics. This happened in oil-rich Norway, where there was a continuous increase in the amount of funds channeled into the health sector, without any period of major slimming of the welfare state as in the other Nordic countries. The framework for the hospital regime during these years, which may be described as a political-professional regime, was found in the hospital law of 1970, which set the terms for the operation of the hospital system through a system of state-approved county plans, a system that aimed at a fair distribution of resources across counties. The period of institution building was over, it was now time to develop a fair distribution of health resources.[20] It was probably the strong emphasis on this single aim that put the many voluntary associations and institutional entrepreneurs increasingly on the sideline. It was not necessarily the case that they wanted to continue to play a major role, however, as it

[19] Nordby 1989:254.

[20] Sosialdepartementet 1976.

is typical for the Scandinavian pattern of voluntarism that it is state-friendly; the organizations work with the state, not against it. There is thus a simultaneous increase in voluntary welfare activity and state activity, at least until the 1970s.[21] The medical professional associations also worked with the state, and they took a predominant role in the consolidation and standardization of the hospital system. Both the politicians and the hospital administrators were amateurs in comparison with these national associations and their experts, particularly the physicians that in reality ran the various hospital departments and clinical disciplines. There was a trend towards democratization within the hospitals also, however, as the nurses and other professional associations wanted to have more influence. These professions were also organized on a national level, however, and they had to make an argument based on the idea of equity in distribution of health resources in order to get acceptance for their demands.

The institutional logic of Norwegian health care services between 1972 and 2002 may perhaps be seen as a combination of political and professional governance, meaning that local and national politicians had a great deal of power in health affairs although they depended on individual medical experts, as well as professional bodies and associations, for information and advice, since this was a way to establish trust in the media and in the public. This means that the politicians and the hospital administrators were amateurs in comparison with the physicians and their professional national associations. This system has been challenged, and there has emerged a stratum of professional health administrators with an economic-administrative background, as well as a whole range of expert bodies and patient representatives demanding transparency, quality control and free choice between providers. The trend is thus towards external control and organizational control of a system of professions that used to be autonomous. The trend is also towards looking at the hospital and its departments and clinics as accounting units, the medical system as a quasi-market and the patients as customers. This development has been rather slow, however, at least in Norway. If there is a phase dominated by a managerial logic, where the hospital becomes an accounting unit, then this did not arrive until 2002, as far as Norway concerns. This happened earlier in the case of Sweden, while Denmark seems to display the slowest introduction of a managerial logic.

It seems that the historical combinations of logics, actors and governance structures in Norway differs quite clearly from those in the USA, as portrayed by Scott and associates (2000). The development largely seems to have moved away from a loose, entrepreneurial setting where local projects in conjunction with local actors (public as well as voluntary and «private») played an important role. The shift is thus towards increased «statism» in the hospital system along with the influences of the medical profession. However, the hospital reform of 2002 manifests the influence of neo-liberalism «the Norwegian way», increasing state influence through management- and market-oriented ideas (possibly at the expense of the professions, certainly at the expense of the local democratic level). This may either only be representative of

[21] Selle 1996, Eikås and Selle 2000.

Norway, or perhaps it may fit with development patterns in other Nordic countries. This will now be discussed, first making a comparison with Sweden, then Denmark.

The Swedish reform story[22]

In Sweden, provision of health care has been a public responsibility more or less since the 17th century, as towns and cities employed physicians for publicly provided care. As the counties (landsting) were established in 1862, health care was introduced as one of their principal responsibilities. In 1864 the parliament introduced a standard for hospital boards that became the norm for the organization of healthcare in Sweden. This was implemented all over the country already in 1865.[23] As in Norway, it was popular movements and voluntary organizations that mobilized for the development of health services, but they were less successful in introducing a nation-wide system of sickness funds, particularly until the mid 1930s.[24] The Swedish health system was more state-centered and hospital-centered than the Norwegian and Danish, however.[25] Still, the development towards state planning and specialization was gradual, as the counties' formal responsibility for hospital care was not introduced until 1928, through the Hospital Act. A share of 60–70 per cent of physicians in Sweden was either hospital physicians or medical officers between 1920 and 1950, whereas the same share in Denmark was between 30 and 40 per cent.[26] More than 50 % of Swedish physicians were employed in hospitals by the end of the 1950s.[27] There was an increase to 65 % in hospitals in 1985, whereas there was still only a share of 50 per cent in Norway.[28]

After World War II the first steps towards universal coverage were taken, at first through the 1946 National Health Insurance Act. However, this act was contested, mainly by the medical profession. Accordingly, the act was not implemented until 1955, due to the desire for consensus among all involved parties. The 1969 local government reform and the 1970 'Seven Crown Reform' mark a turning point in Swedish health care development. The reform highlighted that specialized health care was the responsibities of the counties, and most physicians had now become salaried employees of the

[22] The overviews of reform history in Sweden are mainly based on the following sources: European Observatory on Health Care Systems 2001b, European Observatory on Health Care Systems 2002b, Møller Pedersen 2002, and Green-Pedersen 2003.

[23] Axelsson 2000: 48.

[24] Therborn 1989, Itu 1980:48.

[25] Erichsen 1995, 1996.

[26] Ito 1980: 56.

[27] Berg 1980: 31.

[28] Erichsen 1995:195.

counties. In the early 1980s, Denmark used 73,9 per cent of total health expenses on hospitals, Sweden's share was 72,9 per cent, whereas Norway spent 69,9 per cent.[29]

Thus, one can speak of a period of incremental development approximately ending in 1970, dating back at least two hundred years. The medical profession was important in this period, as the profession itself was developing both in terms of the total number of physicians and their relative importance to health care. In addition to the medical profession, a conglomerate of different public actors played different roles through the period. From the 1928 Hospital Act and then on, a more planned governance of health care became the norm. Further, from around the Second World War, there was an increased focus on equity in health care. At the same time, the counties have become pivotal points for organizing health care, indicating a decentralized approach. Keeping in mind Scott's (2000) dimensions, it seems that this first period, ending around 1969, displays an involvement of the state that differs from the Norwegian case.[30] Although the medical profession was important in both countries, the role of the state is more evident in Sweden, both through the counties' role and through a more deliberate state approach to healthcare in general and hospitals in particular.

By 1974, according to the 1969 local government reform, the number of municipalities was to be reduced drastically from 2498 to 284 – steadily increasing the importance of counties. The Seven Crown Reform reform made health care considerably more accessible to low-income groups, the national health insurance authority reimbursing the counties' expenses, reducing patient fees. The 1970s were characterized by long-term plans for health care, plans that more or less depended on the medical professions' perceptions of what 'the common good' was. The National Board on Health and Welfare (until 1968 the Royal Medical Board) remained responsible for the supervision of both health and social care.

In all three countries, the healthcare system has been debated with an increasing intensity since the 1970s, and this has led national authorities to get more involved in health care planning, although most health care provision has been decentralized to the county level. This is not to say that healthcare units in Sweden were meticulously governed from the central level. Rather, broad plans and aims were established at the central level, and subsequently left for the counties and municipalities to pursue. Perhaps most characteristic, the central engagement in health care was accentuated without leaving a decentralized model behind. The 1970s thus seem characterized by the establishment of the counties as the principal units in health care provision, with a relatively strong medical profession providing guidelines for the long-term health plans. It should be noted that apart from the Seven Crown Reform and the implementation of the local government reform, no major changes were initiated until the early eighties.

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[29] Erichsen 1996:74. However, it has been maintained that by 1968, hospitals accounted for 90 % of health care expenditures in Sweden (European Observatory on Health Care Systems 2001b:7). In comparison, the planned expenditure for Norwegian specialist care in 2003 still adds up to approximately 70 % of the total budget. (St. prp. Nr. 1 (2002–2003).

[30] The Nordic medical professions were historically much more involved in state affairs than in the USA, however, and it is thus not necessarily a contradiction between professional strength and state power, at least not to the same extent as in the USA (Erichsen 1995).The term «professional-political regime» may be used to refer to a situation with a strong state and a strong medical profession.

The importance of A) the counties as the prime level in health care and B) the medical profession's part in the long-term plans leads to a notion that other actors than the central government played an important role. The counties remained the focal point of Swedish health care in pair with professional medical considerations, although within the general frames of broad central planning. Norway differs from Sweden at this point in time, in that the importance of direct central political initiative continued well beyond the 1970s, and perhaps as long as the turn of the century. Perhaps one can speak of a period where a specific relationship between different levels of governance (in particular the relationship between the central government and the counties) became embedded in the healthcare system, establishing the counties as important actors both in a political and an «operational» sense. That is, a definition of roles occurred, mainly through the influence of three major elements: The strive for equity in healthcare, professionalization and specialization in the field of medical knowledge , and the establishment of health governance at the county level.

In the case of Sweden, it seems natural to draw a distinction between the period of political mobilization for decentralization in the 1970s , and the development from then on. This is further accentuated by the nature of the reforms implemented from the early 1980s and onwards.[31] The 1982 Health Care Act formally placed the main responsibility for planning, operating and financing health care services at the county level, emphasizing the already decentralized system. Large-scale decentralization followed throughout the 80s, which in turn raised financial questions – responded to by the so-called 'Dagmar reform' in 1985. In essence, cost containment became an increasingly important factor in Swedish health care as the country encountered economic crises, while one simultaneously emphasized universal coverage and the principle of equity. The 1980s saw the early introduction of New Public Management-oriented measures, much because of the intention to create a more cost-efficient health care system based on neo-liberal inspirations.[32] In the latter half of the 1980s some counties introduced various forms of waiting list guarantees, while further decentralization took place – the counties became ever more important in Swedish health care. The decentralized approach may in part seem challenged by the 1988 establishment of six planning regions for highly specialized care, but one should keep in mind that they were formed for the benefit of the counties' ability to provide cost-efficient health care services.

In the 1990s a neo-liberally influenced market orientation occurred in several counties (Södermanland, Jämtland, Dalarna, Bohus and Stockholm), including the introduction of the purchaser/provider split, DRG-based reimbursements, and extended patient choice. However, these elements were applied differently. For instance,

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[31] However. see Axelsson (2000) who has presented the following periodization: 1865–1965: traditional organization, 1965–85: bureaucratization, 1985–1992: decentralization, 1992–96: market orientation. His argument is based on the idea of a pendulum change from centralization to decentralization. In this perspective it is the period from 1965–1985 that is the major period of centralization. His major level of analysis is the hospital, and it thus seems as if political decentralization was associated with a centralization at the level of the hospital.

[32] Green-Pedersen 2003.

in some counties health districts became purchasing bodies while other places the purchasing body was the county itself. Long waiting lists gradually became a concern centrally, and additional funds were allocated to this. In 1996, the system for grants to counties was unified, creating an objective block grant system. Two years later, counties started taking over the economic responsibilities for medicine from the National Health Insurance. Patient rights were also very much in focus during the nineties, there were changes in waiting list guarantees both in 1992 and 1997 and as the Patients' Rights Reform came about in 1999.

In effect, the main impression from the last twenty years of reform history in Sweden is that the welfare principle of equity is combined with an ever-increasing focus on neo-liberal ideas. The devolution of powers from the central level is one example, market-like arrangements and patient rights another. Although the emphasis on cost-containment and market mechanisms at the county level indicate that the idea of an *Era of Managers and Markets* seem appropriate, two aspects of the Swedish system dates further back than the neo-liberal period. . First, the county as the main level in health care has long traditions, as health care has been an important task for counties from their establishment in 1862 up until today. Second, patient rights reforms may just as well be grounded in the principle of equity as in the idea of patient as 'customers,' although extended choice etc. may well be connected to neo-liberalism. Nevertheless, the introduction of neo-liberalistic measures represents the introduction of a new way of thinking, a different institutional logic than those oriented towards either healthcare or equity as main concerns.

It is clear that the Swedish case differs somewhat from the Norwegian, perhaps most in that neo-liberal ideas in a more principled way came to characterize the 1980s and 1990s. Furthermore, the broad delegation of tasks, responsibilities and powers to the counties seem to indicate a difference from Norway, where counties both were created and given healthcare responsibilities at a later point in time.

The Danish reform story[33]

How does the Danish case compare the cases of Norway and Sweden, utilizing Scott's framework? Just as for the two previous accounts, special emphasis is put on actors, logics and governance structures as main parts in understanding Danish reforms.

The early stages of hospital development in Denmark date back to the 18th century. The number of hospitals steadily increased throughout the coming decades, as they provided both general treatment and more specialized care. The hospital was mainly seen as a «local project», connected to towns and counties.[34] At the start of the 1930s, the idea of specialization and centralization in hospitals was introduced, and it appeared

[33] For the Danish case, empirical overviews are mainly based on European Observatory on Health Care Systems 2001a, European Observatory on Health Care Systems 2002a, Vallgårda 1992, Vrangbæk and Christiansen 2003, and Møller Pedersen 2002.

[34] Borum 2003.

that the hospital was also part of a «medical project», and later a «county project».[35] This was in part a response to the fact that most hospitals were small and had a low degree of specialized care and treatment, providing mixed services within the same wards. County politicians in part welcomed this specialization and centralization, although a resistance among parts of the medical profession arose. As a result, the establishing of larger and more specialized hospitals was relatively fast and free of problems, whereas the closing of smaller community hospitals was much slower. As in Sweden, the number of physicians employed in hospitals increased greatly, simultaneous to the general growth in the hospital sector (both in the number of beds, admissions and bed days). Even in the 1930s, there were many who preferred patient-centered holistic models to the prevailing specialized treatment models.[36]

The specialization of hospitals that was initiated in the 1930s continued at accelerated speed after the Second World War, along with large investments. Economic costs were high and constantly increasing, but an almost total political acceptance and support of the existing hospital policy ensured continued expansion of the hospital sector. Vallgårda (1992) argues that the years 1945–60 represents a consolidation of the hospitals as the main element in Danish healthcare provision, as the political discourse on health care revolved around treatment and hardly touched topics such as primary care and preventive efforts. The hospital as a local and medical project remained the focal center of healthcare policy in Denmark for another 10–15 years.

Interestingly, the orientation towards hospitals remained uncontested throughout the period. The consensus around the basic structure of healthcare provision remained strong, since the efforts to specialize and centralize in effect did *not* create propositions to change the main features of town and county responsibility of hospitals. A main characteristic of Danish health care in this period was the predominant position of the medical profession. This is in part evident in that health care issues were debated in technical and professional terms rather than on the basis of politics. Furthermore, the efforts to specialize and centralize hospitals was a matter of professional judgment, allowing towns and counties to remain responsible for health care – eventually following broad guidelines laid down by the central government in concerted action with the medical profession. However, this means that the local hospitals and municipalities found themselves without real influence over the shaping of the hospital system, as the medical profession and the central health actors together were the prime influences towards specialization. This coupling of the professions and central political actors can be recognized in Norway and Sweden as well, although the relationship itself may be different. In Denmark, however, the contents of these influences related to the definition of what hospitals were to be, and perhaps more so than to the establishment

[35] Borum 2003.

[36] Vallgårda 1992:391. Vallgårda provides an extensive treatment of the history of Danish specialized healthcare, perhaps the most detailed overview in the historiography of any Nordic system. Her history begins in 1930 and ends in 1987, and the periodization is based on the degree of consenus in the debates about healthcare. She found that there were more disagreement and debates in the period of establishment (1930–45) and beginning downturn (1974–1987) than in the two periods in between (consolidation 1945–1960 and «golden age» 1960–1973) when there was a major consensus among political parties as well as in the public in general. The discussion during the periods of polarization centered on the benefits of specialization versus decentralization.

of a new or different governance structure. This is perhaps one of the reasons why counties and hospitals could remain as the focal points of Danish healthcare, in spite of the central government being a driving force for specialization. One should note that Vallgårda (1992) has argued that there was actually a trend towards less specialization in Danish hospitals in the 1980s, when the rise of costs had to be contained as the legitimacy for hospital services was decreasing.

The 1970s saw an introduction of several reforms, many of which were oriented towards the counties. It was an era of hospitals as local and political projects. Although towns and counties had in practice been responsible for hospitals since the eighteenth century, it was not until 1970 that this responsibility was formally placed on counties. As in the early 70s reforms in Sweden and Norway, this was part of a larger restructuring and reform of local government, where the number of municipalities in particular was greatly reduced. The reforms that followed during the next five years may in part be understood as a consolidation of a long tradition for decentralized healthcare in Denmark, as well as being in sync with traditions of local and regional governance and democracy.[37] Shortly, it may well be claimed that the orientation towards the regional level was strengthened even more, for instance through the allocation of planning and financing responsibilities and the transferal of psychiatric hospitals to the counties.

However, the power of the medical profession seem to have diminished somewhat, as a result of a greater polarization between political parties and a tendency to include health care issues in political programs. As such, the entire healthcare sector seems to have become more politicized, although this does not imply a greater involvement of the central government in direct governance (as the decentralized model prevailed). The counties remained the principal public actors, eventually taking over the hospitals operated by the state and the municipalities – both psychiatric and somatic.[38] This means that there is a tight correlation between financial, operational and political responsibilities at the county level, and this seems to be a characteristic trait portrayed in the years 1970–80. As Scott et al. (2000) has described their second era as one of federal involvement, similar to what one may refer to in Borum's term as the hospital as a national project, the Danish case is deviant. Hospitals remained important in health policy, but the counties' role was strengthened more than the national state. By 1978, the only state-operated hospital was the National Hospital. Although equity was a concern in the central government, the approach was local. In many ways this compares to the Norwegian case, but the important exception is the Danish counties' ability to adjust their own tax level in financing health care. In practice, this means a lesser central involvement in Denmark than in Norway.

From the early 1980s and onwards, a series of measures usually associated with neo-liberal ideas have been taken in Denmark (although to a lesser extent than in Sweden, and even Norway). It should be noted that these changes to a certain degree seem to have occurred in an incremental way, rather than as a consequence of a general neo-liberal plan. A wide array of changes have been set in motion, such as the introduction

[37] Vrangbæk and Christiansen 2003.

[38] Report from a government commission; Strukturkommissionen 2004.

of frame budgeting (autonomous hospitals), management reforms (the troika model), and further formal decentralizing of planning and approval responsibilities to the county level. In continuation of this, reforms were made concerning patient choice and waiting list guarantees during the 1990s. Frame budgeting proved relatively effective as a measure for cost containment, which (in some contrast to Norway, in particular) has been – and continues to be – very important in Denmark. At last, two more aspects should be mentioned. First, one should make notice of the reorganizing of political and administrative responsibilities into one 'health committee' at the county level, increasing the coordination between primary and specialized care in the important local politics. Second, the creation of the Greater Copenhagen Hospital Corporation must be mentioned, as it represents an atypical organizational solution in Denmark. Its governing organs involve two municipalities, ministry officials, and external members. The National Hospital has been included in the corporation, leading to a greater involvement of the state in financing than what is usual in Denmark.

Kragh Jespersen has argued that the counties' heyday actually was limited to the 1970s, for two main reasons.[39] First, the need to constrain costs has restricted the counties' possibilities for making their own priorities. Second, as the central political level in practice has not delegated responsibilities to the counties since the mid 1970s, the impact of NPM-oriented measures has been relatively small. That is not to say that no such measures have been taken, but rather that the counties have been forced to relate to central influences (for instance the introduction of patient choice).

It has been argued: «If the Danish health care system is unique, the uniqueness has to do with the lack of reforms.»[40] Is this the case? Market models have played a more limited role than in Sweden. Certainly, financial authority has been introduced and also global budgets. However, there has not been any major effort to introduce provider/purchaser models, and the organization of the primary health care sector has remained largely unchanged. The most significant market-type reform of Danish health care is the patients' right to choose a hospital in a different county, which was introduced in 1992, but Vrangbæk and Christiansen (2003) has argued that the effect of this has been limited. Although they do not represent a revolution of the health care system, the reforms in Sweden have been substantial. This is not the case in Denmark, mainly because of the incremental development of the hospital system. Furthermore, there seems to have been a tension between the counties and the effects of different measures taken by central actors, leading up to a weakening of the counties. At the same time, the basic county-oriented structure has remained virtually unchanged, creating something of a discrepancy between the formal features of the system and the actual patterns of influence. In talking about managers and markets, it should be noted that there has not been any overall reform. Rather, the implementation of market-like arrangements has been incremental and partial; something that seems to fit Denmark's tradition for incremental change.

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[39] Kragh Jespersen 2001.

[40] Green-Pedersen 2003.

Denmark, Sweden and Norway: Do the cases correspond?

Departing from the assumption that the model presented by Scott and his colleagues (2000) only in part fits the Norwegian, Swedish and Danish cases, a question remaining is whether the periodization outlined for Norway provides a match with the other Scandinavian countries. Starting with the observation of changes being made in local government around 1970, all three countries (although to different extents) decentralized responsibilities for health care to counties. Because of this, it seems appropriate to draw a line here. However, the question of what happened needs to be addressed in substance. In the Norwegian case, we emphasized the role of the welfare commune, local entrepeneurialism and local provision of services before the 1970s. In Sweden, the tie between the medical profession and the state seems to have been stronger, as health care through the years revolved around the hospitals and the medical officers. The counties gradually came to be the central level in providing health care to the Swedish population also, but perhaps the civil movements that were so important at the local level in Norway played a lesser role. Denmark was characterized by the historical importance of private practitioners, a higher degree of urbanization and thus also an easier access to local hospitals and general practitioners. In difference from Sweden, the political discourse to a larger extent revolved around the hospitals themselves, rather than the need to conceptualize a national plan for healthcare. In this respect, Denmark and Norway seem relatively alike, as the local-medical projects were important. Comparing all three countries, the Swedish focus on the counties already before 1970 seems to part from the Norwegian and Danish approach, which to a larger extent revolves around the municipalities and the local hospitals.

Around 1970, all three countries implemented local government reforms. In Denmark, this can be understood as a culmination of a historical tradition for decentralized health care, placing the counties at the core financially, politically and operationally. This also seems important in Sweden and Norway, but in a somewhat different way. Long-term plans were introduced for Swedish healthcare, and in Norway a general debate about the hospital system arose in connection to new legislation. An increasing focus on equity as an overriding principle in health policy seem to have been common for the three countries, but there were differences in how one wanted to achieve this. As in the other Scandinavian countries, revenues of the county councils come from local taxes and block grants received from the central government also in Norway. Taxes are fixed by the central government, however, creating a centralized system of county finance, in contrast to in the other Scandinavian countries where the counties can set their own rates. As the counties in Sweden and Denmark to a larger degree were able to channel funding to their own healthcare projects, the Norwegian counties were dependent on the central state economically and in part politically (in spite of the establishment of elected county councils). The counties were not allowed to experiment with their own models in the same way as in Sweden in the 1980s and 1990s. In all three countries, professions continued to play an important role, but it

seems like the revival of the medical project was particularly strong in Denmark as a consequence of the introduction of the function-bearing unit in 1998.[41]

The years after the beginning of the 1980s seem interesting in a comparative perspective, as there are differences between the countries from then on that should not be overlooked. At least three features should be pointed out: Firstly, Sweden was the first in introducing neo-liberal ideas to healthcare and hospitals, i.e. through the 1982 legislative act[42] that in its rationalistic approach initiated planned decentralization based on efficiency-oriented criterions. Sweden stands out as the most plan-oriented country of the three, also in terms of implementation of neo-liberal measures. From the early eighties and onwards, there has been a continuous development in the direction of delegation of powers, financial leeway at the county level, and market-like arrangements. This development can be connected to the governmental approach to healthcare, where an opinion that a decentralized system is desirable seems to prevail. This is evident in the counties' ability to levy their own taxes for financing hospitals and health care. Perhaps is this a result of central planning oriented towards the decentralized operation of hospitals especially and health care in general.

Secondly, what we have described as the professional-political regime in Norway extended far beyond the turn of the decade. Neo-liberal ideas did not pick up until approximately ten years later than in Sweden. When these ideas were introduced it was in a much more incremental way, as the political game centring on health care continued to play an important role. The parliamentary situation, with minority governments, as well as the continuing tradition with professions oriented towards equity on the national level, may have contributed to this. Norway compares to Sweden in that counties remained central in health care, but differs in several other matters. For instance, issues of responsibility were not clarified, as the hospital system was drawn into a «blame-game» between the central government and the counties. Furthermore, the counties' dependence on the state for finances left a considerable amount of control to the central government. At the same time, counties were politically engaged in the operation of hospitals; creating a dilemma that was largely unresolved until the 2002 hospital reform (this is not to say that county politics no longer include health issues). Although neo-liberal measures certainly were taken at various times (block grants, extended freedom of choice etc.), central involvement continued (for instance in placing demands on the health regions and the state being responsible for funding and general goals). Professions continued to play an important role in the construction of a complex area of health politics, in mix with the counties as political actors and the central democratic and governmental actors as financial providers with intentions for active intervention.

Thirdly, Denmark only in part introduced neo-liberal measures in healthcare during the 1980s. Changes certainly were incremental, represented by such facts that management reforms were introduced mainly on a hospital-by-hospital basis rather than through holistic reforms, and that frame budgeting was introduced at different times in different counties. Denmark's continued incremental approach is also evident in the

[41] Borum 2003

[42] Hälso- och Sjukvårdslagen

practice at the central level: A health ministry was not founded until 1987, but already in 1988 central planning of healthcare was dismantled and left to the counties. At the same time, measures were taken to strengthen the ties between politics and administration at the county level, in effect establishing the counties as the main political actors. Hospitals were also in Denmark increasingly drawn into a political minefield, but the county level is still a primary political actor along with central and professional actors «inspiring» them to take measures in certain directions.

Currently the situation in the three countries is somewhat different. Norway has introduced its centralizing hospital reform, and the central governments regain power over hospitals at the counties' expense. In Denmark, patient choice and waiting list guarantees have been important at the central level, but the counties remain influential – in day-to-day operation of specialized healthcare services. Sweden also remains on its planned decentralized path, although the state and the counties now cooperate to eradicate waiting lists. The impression is that the state never let go of its attempt to gain control over hospitals in Norway, and that this control now is strengthened even more. In Denmark, the state seems to have involved itself in matters that are politically important (such as long waiting lines), something that can also be said for Sweden. The Swedish exception, however, seems to be that counties are perceived as desirable as part of a 'central plan' for organizing hospitals.

Conclusion

We set out to use Scott's theoretical dimensions to highlight the impact of reform activities and development patterns in healthcare in the various Nordic countries. For the Norwegian case, we have developed an alternative way of framing the issue and emerged at the following periodization:

- Before 1972; The welfare commune, institution-building, parallel growth in voluntarism and statism in welfare provision
- 1972–2002: Professional-political regime: planning and professional autonomy. Voluntary organization and patient organizations take a new role, more as interest groups, their roles in the actual operation of institutions decreasing.
- 2002→: Managerial regime based on the idea that hospitals are transparent accounting units, or enterprises, that are in competition with each other. A new role for voluntary organizations and patient organizations?

We started out with the epoch of local welfare entrepreneurs, since it was the local entrepreneurs, the voluntary organizations and local politicians that mobilized the resources that were used to take care of local health problems, e.g. hospitals. The era of local entrepeneurialism lasted until the early 1970s when a law was taking effect that allowed the state to intervene in the local running and planning of hospital affairs. We have discussed how Sweden and Denmark may vary along the dimensions provided by Scott et al. and the Norwegian case, respectively. So far we have only looked into a few of the available sources on the history of Nordic healthcare, mainly sources on the

history of reforms and the history of health politics. It may be useful to collect data in a more systematic way in order to map the role of the various actors and the interest they have taken in the hospital and their impact on the health care system.

Our approach is somewhat different from Scott et al. (2000) since we rely on historical sources and try to establish epochs of institutional logics, governance regimes etc. based on historical sources, whereas Scott et al relied on an empirical study of organizational populations. Our approach is also oriented towards mapping changes at the cognitive-symbolic level as well as structural level, however, since we emphasize the relationship between actors and how they experience their problems, as well as the relationship between actors, events and structural development patterns. The framework presented above has been more oriented towards studying changes in the healthcare sector in a comparative perspective, regardless of whether the actual changes were initiated by reforms or not. Reforms may matter or not depending on whether they release energy and trigger changes in institutional logics among major actors, lead to changes in power structures etc.

One may then ask under what conditions reforms are likely to have important consequences, i.e. lead to changes in institutional logics. The case of Norway 2002, when there was a large-scale reform, may be used in contrast to the other Nordic systems. Why did this reform occur in Norway, and not elsewhere? To what extent is it likely to have major consequences? What are the prospects of Norwegian health reform to bring a regime change, the kind of change that seems to have been under way in the Swedish hospital system for a while?

It seems that Norway has not had the same kind of economic downturn; it has not decentralized the responsibility for bringing in tax money to counties. There has not been experimentation with market models on the county level in the same way as in Sweden. Other preconditions for the Norwegian delay culminating in a «big-bang-reform» may have been the strong position of national professional associations and also a history of peripheral mobilization against the center. Although displaying characteristics that are reminiscent of this, the Danish system has followed a more incremental path. Thus, in the Danish case, it seems the preconditions of a large-scale reform as the one in Norway depend on whether the counties, the professions, the central actors and the traditions for local government remain compatible. That is, whether or not the Danish hospital system performs to the satisfaction of both central and local political actors, the population and the professions. Certainly, health politics at the central level has come to play a larger role also in Denmark.

Is the Norwegian hospital reform going to bring about the same kind of change in institutional logic as experienced in Sweden during the 1990s and in the USA from the 1980s? Clearly the options for Norwegian politicians to pursue a top-down control strategy is still there, since the health minister and the parliament may intervene into the daily affairs of the regional hospital enterprises, if they want to. Attempts to do so may fail, however, and the possibility for a new regime also in Norwegian hospital services remains open: Not managers and markets, perhaps, but certainly managers that want to display an enterprise identity to the outside world.

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