The Introduction of Choice in Scandinavian Hospital Systems

Arguments and Policy Processes in the Danish and the Norwegian Case

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UNIFOB AS

MARCH 2004

Working Paper 5 - 2004

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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

This paper describes a comparative study between free choice of hospital in Denmark and Norway. The starting point for the study is that the Scandinavian health care system has historically been dominated by a decentralized welfare state tradition. There has been a strong emphasis on equity and regional democratic control through the county institutions. To introduce free choice of hospital in this type of system is a challenge for a number of existing perceptions, structures and procedures in the Scandinavian system. From a system level perspective the planning capacity and the strong link between a given regional population and chosen level of public service are weakened. From a user perspective the relationship between the individual citizen and the health care system changes in the sense that patients become more empowered, when they can choose hospital.

With this starting point the paper present an analysis of the arguments and the policy process for introducing free choice in the two countries. The analysis is made from two theoretical perspectives. First, from a rational perspective and second from a garbage can perspective.

The results of the study show that even if there are large similarities between the two countries there are also large differences. That concerns timing, rhetoric and content of legislation. The explanation to the differences can help us to understand who it was possible to introduce free choice of hospital in the two countries. In Denmark it was possible because of the general consensus on the fashionable idea of choice that opened a political window for action. While in the Norwegian case it was possible because the government wanted to put pressure on the health sector in order to create better planning and use of resources. In Denmark the initial implementation of choice was adjusted to the dominant policy objectives of macroeconomic control through regional planning, while in Norway the chosen solution reflects a more limited concern for expenditure control and a greater willingness to experiment.

Sammendrag

Notatet er en beskrivelse av en sammenlignende studie av fritt sykehusvalg i Danmark og Norge. Utgangspunktet for studien er at det skandinaviske helsesystemet tidligere har vært dominert av et desentralisert velferdssystem. Det har vært et sterkt fokus på likhet og regional demokratisk kontroll. Å introdusere fritt valg av sykehus i den typen system er utfordrende for eksisterende forestillinger, strukturer og prosedyrer i et skandinavisk system. Fra et systemnivåperspektiv er planleggingskapasiteten og den sterke linken mellom den lokale befolkningen og politikerne svekket. Fra et brukerperspektiv er relasjonen mellom individet og helsesystemet endret i bemerkelsen at pasientene har fått større innflytelse gjennom at de kan velge sykehus.

Med dette utgangspunktet presenteres en analyse av begrunnelsen og policyprosessen for innføring av fritt sykehusvalg i de to landene. Analysen gjøres fra to teoretiske perspektiver, dels fra et rasjonelt perspektiv og dels fra et garbage can perspektiv.

Resultatet fra studien viser at det til tross for store likheter mellom de to landene også finnes store ulikheter. Det gjelder timing, retorikk og innhold i lovgivning. Forklaringen til forskjellene hjelper oss å forstå hvordan det ble mulig å få gjennomslag for å introdusere fritt sykehus valg. I Danmark ble det mulig gjennom at NPM-ideene var veldig populære da innføringen var aktuell i Danmark, mens det i det norske caset mer handler om å sette press på helsesektoren for å skape bedre plannlegging og ressursutnyttelse. I Danmark ble tilretteleggingen for fritt sykehusvalg i utgangspunktet tilpasset de dominerende policy-mål om makroøkonomisk kontroll og regional planlegging. Policy design og implementering ble derfor mindre vidtgående enn retorikken, mens det i Norge har blitt mer tilrettelagt for et reelt valg, og hensynet til makroøkonomisk kontroll og regional planlegging har vært mindre.

Introduction

The Scandinavian health care systems have historically been dominated by a decentralized welfare state tradition. There has been a strong emphasis on equity and regional democratic control through the county institution ('amter' in Denmark and 'fylker' in Norway). Hospital services have been perceived to be at a high and relatively uniform level within the Scandinavian countries, although the decentralized governance structure would also leave room for local experiments within the regional planning systems in order to accommodate local preferences and conditions.

Introducing free choice of hospitals challenges a number of existing perceptions, structures and procedures in the Scandinavian systems. From a system level perspective the planning capacity and the strong links between a given regional population and the chosen level of public service and taxation are weakened. From a user perspective the relationship between the individual citizen and the health care system changes in the sense that patients become more empowered, when they can choose hospital. The introduction of choice is likely to affect expectations, norms and behavior of the different actors involved in health care. Changes may not take place over night, but it is likely that the introduction of choice will initiate processes of transformation in the perceptive and behavioral schemes for patients, general practitioners, hospital personnel and managers and public bureaucrats and politicians. Depending on the exact legislative design it may also create opportunities for a more active involvement of private sector actors than previously. All in all a number of both expected and unforeseen changes are likely to take place. We will discuss such issues in a subsequent paper. This paper focuses on arguments and policy processes leading to the introduction of choice in Denmark and Norway.

In theoretical terms we contend that that arguments for introduction of choice can be seen in the light of at least two sets of theoretical notions namely ideas of a switch from planning to quasi markets in health care (see for example Jacobson 1994, Østergren and Sahlin-Andersson 1998), and ideas of a stronger role for patients in modern health care in terms of patients rights and demands for increasing and more individualized service levels (Westerhäll 1994, Trädgårdh 1999). Despite the growing body of research that acknowledge the importance of choice in health organizations, yet there is little focus on how arguments are developed within a decentralized welfare systems where choice is creating a large challenge to existing perceptions, structures and procedures.

We find it interesting to investigate such policy processes in the Scandinavian countries as the contrast to a public decentralized welfare system is particularly strong and the conflicts between decentralized planning and choice may be particularly clear in these systems. The Scandinavian experience can thus be illuminating for many of the issues and concerns that are either developing or have developed as choice has been introduced in many other European countries. Especially because the chosen countries – Denmark and Norway – so similar in the sense of having a decentralized welfare

system chose so different ways of arguing for choice and designing choice as a policy solution.

In this paper we focus on arguments and policy processes, more precisely we describe and analyze why choice entered the political agenda in Denmark and Norway from two theoretical perspectives; a rational and a garbage can perspective. What were the principal arguments and how can we describe the political processes leading to a decision on choice? What was the exact content of the choice legislation in the two countries and how can the dominating arguments and/or the nature of the political processes leading to decision be explained?

We argue that the process of decision-making concerning choice can be analyzed from both a rational actor perspective and a garbage can perspective. In the following section we will first describe two basic models of choice in greater detail then the two theoretical perspectives are described – rational and garbage can. The theories are applied in the subsequent presentation and analysis of the two country cases and the final discussion of general lessons regarding the introduction of choice in public health care systems.

Two basic models of choice

The theoretical field dealing with policy design is vast and ranges over multiple disciplines (Parsons 1995). In the following section we focus on two opposing views that build on fundamentally different assumptions in regards to the arguments and conditions for introducing choice as a policy change in health care. The first view, which is based on new liberal arguments for a free marked are described as being more efficient, more customer oriented and using more effective production methods compared to plan economy. The second view, which focuses on patient's rights is articulated in acts and the role the act has in organization processes.

Introducing market forces in public hospital care – New Public Management and transition from voice to exit

The past decades have seen a number of reforms in the general public sector of many countries (Pollitt and Bouckaert 2000, Ferlie, Ashburner, Fitzgerald and Pettigrew 1996, Kettl 2000). Although there have been significant differences in force and flavor there seems to have been a general European trend to at least consider some of the reform elements from the change agenda that have been labeled New Public Management (Hood 1991, Pollitt and Bourkaert 2000, Kettl 2000).

Health care is no exception although many countries have been more cautious in the actual implementation of NPM ideas in this area than in many other public service areas (Saltman and Von Otter 1992, Ham 1997). NPM is a broad term that has been used to label a number of different and not necessarily coordinated or consistent change processes. One way to summarize the NPM ideas is to claim that they are a loosely

connected and sometimes conflicting set of recommendations and ideas based on a theoretical heritage of new institutional economics and management thinking (Hood 1991).

NPM proponents typically focus on translating and adopting private sector concepts related to the three Ms of market, measurement and management into the public sector (Hughes 2003, Walsh 1995). *Markets* or market like instruments are seen as a way to improve efficiency and quality of public services by creating competition and transparency and contracts are seen as an important element in implementing market like structures (Lane 2000). *Measurements* in the form of benchmarking and evaluations are also meant to create transparency and competition particularly in situations where true market competition is not possible. NPM usually also implies positive expectations of the potentials of strong and relatively independent *managemen*t in the public sector based on generic private sector management ideas.

NPM arguments for introducing choice are based on an organizational perspective. Customer participation has been discussed as an essential but not quite controllable input to the service. The service provider needs to actively manage client behavior to reduce uncertainty and the participation is considered to have significant effect on the service providers competitive quality (Brignall and Modell, 2000) In other words if the customers choose a hospital, it will get more resources otherwise it will not. Therefore it becomes important to manage client behavior in order to influence their choice of hospital.

The introduction of choice can also be seen as an attempt to change from «voice» to «exit» as the dominating mean of communicating between citizens and public institutions (Hirschmann 1970). The capacity to *exit* is the essential ability of the consumer in a market place. If the consumer is no longer satisfied with the goods or service, she can vote with her feet by choosing to buy from another provider. For the mechanism to work you need alert consumers with access to relevant information and willingness to make conscious choices of provider.

Exercising the option to exit the health care services in a given region does not mean that the citizen gives up voice altogether. She still has the option to vote and express dissatisfaction with the service she has exited from. However, one can speculate that the capacity to exit has a tendency to drive out more direct and active voice involvement, since the most active and alert citizens are also most likely to exit and thus focus attention elsewhere.

If the exit option is to have an effect on the service level there has to be mechanisms for collecting information on how many consumers/citizens exit and preferably also the reasons why. Alternatively there must be economic or other incentives tied to consumer/citizen choices. This is usually the case for receiving organizations in the public sector but may not be directly the case for organizations from which patients choose to exit.

In summary when applying the theoretical lens of markets and «exit» one would expect arguments for choice that relate to improved responsiveness, quality and service at the point of delivery. The exit option may force inadequate hospital organizations to adjust, and may send signals to referring doctors and public budget providers about the popularity (and thus assumed quality and service advantages) of particular treatment

places. To the extent that there are economic incentives tied to loss and gain of patients there may also be pressures for efficiency gain at the organizational level.

A related set of arguments at the system level could be, that choice provides benefits in terms improved match between capacity and demand. Patients that are given an exit option are assumed to look for alternatives with shorter waiting times and better staff and equipment. In the long run this should contribute to evening out differences in waiting times in the country.

Patient rights and improved service options for the individual

The other set of arguments for choice is more based on issues of citizens and patient's rights in regards to the public service provision. The focus in this perspective is on formalizing the individuals right to access, to information and to participation in decision processes regarding treatment. Choice can be seen as one way of extending the set of rights available. It is thus a way of breaking with the monolithic power of the public treatment system to decide where treatment takes place how treatment takes place (and if there are alternatives). Introducing a formal right to choose thus represents a strengthening of the patient power compared to the situation where the home county administration would decide where treatment takes place. Patient's rights can be more or less formalized in legal texts. There has been a strong emphasis on patient's rights in the Scandinavian countries over the past decades and all the countries have introduced patient's right legislation.

The patient rights perspective can be linked to the «public service orientation» model of NPM identified in Ferlie et al 1997:14–15. The idea behind this headline is to differentiate the model from efficiency and management oriented NPM arguments and to identify an alternative strain of reform thinking which focuses on service quality, reliance on user voice and participation rather than exit.[1] The starting point for this perspective is that there is a set of distinctive public sector tasks and values, but that we should explore the possibilities for extending citizen participation and rights within this frame. Choice could be one way of extending rights, without fundamentally altering the principles for organizing health care. The public service perspective is more concerned with developing new ways of communication and collaboration between citizens and public service organizations than with creating competition and exit opportunities. 'Joined up structures' is a British term that describes some of these ideas, another type of inspiration flows from Habermasian thoughts on communicative strategies.

The two perspectives may lead to similar conclusions in some cases. However, there are significant differences in how they would interpret the role of choice, and how they would prefer the institutional infrastructure around choice to be created. Market type arguments would typically present choice as a tool to create more fundamental changes in the rules and structure of the system. This would often lead to arguments for

[1] See for example Nordgren (2003) for a developed discussion on introduction of patient rights in health care sector which started in the early 1990.

relatively strong economic incentives and loosening of control and planning mechanisms in the system. Patient's rights arguments on the other hand would typically be more narrowly focused on the extended functionality for the individual. They would be less concerned with choice as a tool for radical change of system structures, and they would typically argue for models, that are compatible with the existing democratic planning and control system. There would also typically be a concern for maintaining channels for «voice» within the system. This means that openness becomes more important. Health care organizations have to be open and accountable to the public.

Analytical perspectives: Rational actors and garbage can systems

In the previous sections we described two basic models and related arguments that we may expect to see when analyzing the introduction of choice in Denmark and Norway. In this section we turn to analytical perspectives for describing the process of decision-making regarding the introduction of choice. The literature on policy processes is vast and ranges over several disciplines (Parsons 1995, Sabatier 1999). We have chosen to focus on two broad perspectives based on our preliminary assessment of the cases, namely a rational actor perspective and a garbage can perspective.

In *rational actor theories* the starting point is that policy processes are driven by individual and institutional actors' attempt to find solutions that will increase their net benefits e.g. in terms of power, status, wealth, job satisfaction etc. (Buchanan and Tullock 1962, Niskanen 1971, Dunleavy 1991, Scharpf 1997). Political actors enter the game of agenda setting and decision making with specific interests and resources and they attempt to gain influence by processes of negotiation, coercion, persuasion and coalition making. The institutional structure in the system influences the resource bases for entering the game and defines the appropriate channels for interaction (Ostrom 1986, Scharpf 1997). Seen in this light the introduction of choice can be considered a result of bargaining processes between attempted rational political actors pursuing their individual (or institutional) interests. Resources, power relations and rhetorical skills are important element in the process.

In contrast, *garbage can theories* (Cohen, March and Olsen 1972, Kingdon 1995) focus on institutional and temporal factors that restrict the «windows of opportunity» for decision-making and create a seemingly haphazard and coincidental decision process (Cohen et al 1972, Kingdon 1995). Kingdon's «multiple streams» perspective operates with three different streams that occasionally combine to create windows of opportunity for decision making. The problem stream contains information and arguments related to the general functionality of the policy area. The policy or solution stream contains different policy ideas floating in the primeval soup created by professional policy communities. Various policy entrepreneurs promote particular ideas, and there may be fashion trends, which cause particular concepts to rise to the surface in certain time periods. The third stream is the politics stream, which includes the formal political decision processes, which in particular instances create opportunities for policy

decisions that extend beyond incremental changes. Such windows may arise in response to external shocks or to documentation in the problem stream indicating severe malfunctions. In general terms the policy system is characterized by a bias towards incremental processes and it takes considerable forces to create openings for radical change. Timing is crucial, and it is relatively seldom that a situation arises where there is a coexistence of relevant and acceptable ideas in the policy stream and perceived problems in the problem stream. If there is coexistence there are difficult issues of linking problems to solutions in a situation where political coalitions are willing and able to pay attention and make decisions. Due to these many limitations in the policy process it is far from certain that the policy decisions made reflect a rational and deliberate choice. More often we face decisions that reflect coincidental and ad hoc linkages of various problems to solutions. We see solutions that travel through policy systems looking for problems and we see solutions that become infused with different meanings over time and attached to a variety of different problems. The result may be a relatively blurred and seemingly irrational process. Actors may attempt to be rational but the system level results are not necessarily rational in an instrumental sense.

In this paper we will use these general models to analyze the policy processes regarding choice in Denmark and Norway. The studies of arguments and policy processes are linked in the sense that analysis of arguments is the most readily available empirical indication of actor's preferences and strategies in the policy game of health care. Arguments can provide the empirical entry point for the investigation while accounts of historical events linked by theoretically informed modules of small and medium sized explanatory mechanisms (Scharpf 1997: 30) provides the basis for the policy conclusions. Together they present at detailed picture of the events leading to introduction of choice in the two countries. In international terms the Scandinavian countries represent extreme cases in terms of decentralized public control of health care. Denmark and Norway are «most like» cases in a number of ways, but as we will see there are also important differences.

Danish case[2]

General description

«Free choice»/«extended choice» of hospitals was introduced on the public agenda in the early 1990s. It was mainly discussed as a solution for patient complaints about rigid administration of requests for access to particular departments or hospitals in neighboring counties. The counties initially opposed the idea but entered a voluntary agreement on extended choice before a parliamentary decision was made. This can be seen as a defensive move to maintain control over the design of the system. «Free choice» was initially introduced on the political agenda by the liberal conservative

[2] The following analysis is based on minutes from parliamentary debates and systematic reviews of papers and professional journals in the period 1985–1995 as reported in a Danish Ph.D study investigating the introduction and consequences of choice on the hospital system (Vrangbæk 1999).

government but gained support from all major parties in spite of nuances in attitudes (and rhetoric). Due to a change of government in 1993 choice was implemented by the incoming social democratic coalition government, which held power from 1993–2001.

The political decision process in 1992 resulted in a rather cautions approach when spelling out the details of the reform. «Free choice» was transformed to «extended choice» and a number of restrictions and safeguards were built into the policy. In particular it was decided that:

- Payments across county lines for «extended choice» patients should be kept at a low level (an estimated marginal cost level) to reduce economic incentives for counties to build up capacity to compete for patients from other counties
- Counties could decide if they wanted to keep payment for incoming patients at the county level or create incentives for hospitals and departments by letting payment follow patients to the hospital level
- Hospitals were allowed to refuse access for «extended choice» patients but only in times of heavy workloads
- Patients should pay travel costs to non-acute treatment in other counties
- Choice was limited to the same level of specialization and private treatment facilities were excluded from the scheme
- The national government emphasized that counties would not receive additional funding for the implementation of the system

The political decision process reflected the tendency for health policy in Denmark to be driven by pragmatic compromises and concern for the decentralized democratic management. It also reflects a general uneasiness in regards to jeopardizing the dominant health policy goals of controlling expenditures and ensuring access and stability in the system.

The legislative and practical infrastructure has been adjusted several times since 1992. The most important changes have been to improve the availability of information regarding waiting times and to introduce payments based on DRG rates in 2000. The introduction of DRG rates (replacing the system with marginal per diem rates) has increased the payment level for most choice patients and thus changed the incentives to attract «extended choice» patients.

Dominating arguments

The political rhetoric on choice in Denmark covered several different aspects, and often combined arguments from both market and patients rights rhetoric. Parliamentary debates linked the idea to general concepts of choice and competition in public administration. Choice in hospital care was introduced by liberal and conservative parties, but very quickly gained general support, and both market and patient rights arguments were presented from a broad spectrum of political parties. It appeared to be a powerful and popular idea, and national level politicians from all the major parties spoke in favor of the proposal.

In the parliamentary debates it was suggested that extended choice could contribute to evening out waiting lists across the counties. It was also suggested, mainly by politicians from the liberal and conservative party, that extended choice could develop into a true quasi market situation where patient choices would send signals for organizational change.

The counties and most local level politicians initially argued that the legislative initiative was unnecessary as they were already flexible in allowing patients to move across county lines. The counties introduced a national voluntary agreement on choice in 1992 as a preemptive move against legislation.

Patients and patient advocacy groups argued in favor of the scheme while professional groups maintained a low profile. They apparently had limited or diverging interests in choice. Some doctors focused on arguments related to the creation of more flexible referral options and better service options. Others argued that choice could increase workload and waiting lists in some facilities or have negative economic impact on their institutions (if patients would exit to other treatment facilities). Many general practitioners talked about the extra work in individual consultation of patients.

Market arguments were toned down as the parliamentary debates progressed and arguments concerning expenditure and planning control gained importance. In the final remarks for the legislation the emphasis was on extending patient rights and improving the match between resources and demand in order to reduce waiting lists rather than creating markets in health care. In spite of the fact that the more radical market rhetoric was toned down in the final legislation and in spite of the fact that the policy design was rather cautious it can be argued that the decision in fact introduced market like elements in Danish health care. These elements have gained importance over time as cognitive and behavioral schemes for both patients and providers have adjusted.

Policy processes

The process leading to the introduction of choice in Denmark has elements that can be interpreted in both rational actor and garbage can perspectives. In a rational actor perspective it can be observed that national politicians from both sides of the political spectrum supported the idea of choice during the early 1990s. This was probably based on rational expectations that the scheme would be rewarded by increased popularity in the voting population. The arguments ranged from market rhetoric to patient's rights. At the same time there was significant anxiety at both county and national level about the consequences of the reform. Some politicians imagined strong reactions in terms of patient movement. Others emphasized the potential problems for the county planning system and the potential loss of control over overall health care expenditures. In the end most parties grew cautious about the potential consequences and an agreement was made on the rather adjusted model for choice described in the above. In a rational actor perspective this could indicate that national politicians were reluctant to take responsibility for jeopardizing other policy objectives such as expenditure control and equal access, and that they were worried about challenging the powerful decentralized political interests both within their own parties and in the opposition and the legitimacy

of the decentralized democratic system in general. They therefore chose a solution that formally introduced choice, but at the same time attempted to reduce the uncertainty involved in the policy change. The main interest for national politicians thus seems to have been an assessment that this legislation would be popular with the general voting population. The rhetoric of «free choice» and «extended rights» made it difficult to oppose the idea and politicians expected to gain popularity by introducing the scheme.

County level politicians and administrators on the other hand had less interest in the scheme as it could potentially pose a threat to planning (and rationing) abilities at this level. When patients were given choice they could seek treatment wherever it was offered at the home county expense. County level actors were therefore initially opposed to the idea, but once they realized that there seemed to be a strong public and (national) political will to implement choice they decided to enter a voluntary agreement before the actual legislation. This initiative was an extension of previous agreements in some regional areas on choice for particular groups of patients and later for more or less all planned treatments. The national agreement between the counties can be seen as an attempt to avoid legislation by demonstrating ability to collaborate on a voluntary basis. By introducing choice as a voluntary agreement the counties probably hoped to retain control over the details of the scheme.

Patient groups spoke out in favor of greater flexibility in access to treatment. Their arguments were carried forward by the media and particularly the liberal/conservative newspapers, which presented choice a s a way to counteract the alleged bureaucratic rigidities in the system.

Professional groups were split and officially kept a low profile. Many individual doctors spoke out in favor of the greater flexibility based on considerations for patients, preferences for market solutions or expectations of gains for their institutions. Other doctors emphasized the increased burdens involved in advising patients and the uncertainty in terms of planning capacity.

In the end the idea was introduced on the political agenda and quickly become a concept that was difficult to argue against, at least in principle. In terms of practical design the result was less radical than might have been expected. This can be interpreted as a result of the strong decentralized interests and an interest in limiting the uncertainty in regards to competing policy goals.

We can thus see that rational actor perspectives provide plausible explanations for actor responses and policy design in regard to introducing choice of hospitals in Denmark. However, when viewing the process at a broader system level the garbage can perspective becomes a relevant supplement. The «garbage can» or «multiple streams» perspective operates with three different streams that occasionally combine to create windows of opportunity for decision making.

The problem stream contains information and arguments related to the functionality of the policy area. In our case we see that problems such as waiting times, service and quality deficits and perceived bureaucratic rigidity were dominant problems articulated in the general health policy debate. The policy or solution stream contains different policy ideas floating in the primeval soup of professional policy communities. Various policy entrepreneurs promote particular ideas, and there may be fashion trends, which cause particular concepts to rise to the surface in certain time periods. Choice seems to

have been such a fashionable idea surfacing in a policy climate, which was favorable to NPM type ideas, and promoted by national level politicians eager to improve their political profile on the otherwise largely decentralized health policy area. The third stream is the politics stream, which includes the formal political decision processes, which in particular instances create opportunities for policy decisions that extend beyond incremental changes. Such windows may arise in response to external shocks or to documentation in the problem stream indicating severe malfunctions. In our case there were two main contributing factors in the political world. First the increasing weight of health policy in both the public and the political agenda, second the general political climate favoring NPM type initiatives and the related power of the choice idea at the time. This created a parliamentary situation where a broad coalition of parties was willing to support the idea. Choice was linked to several perceived problems in the health sector and seen as a solution, which at least superficially provided answers to several problems. This created a window of opportunity for political decision-making. But the actual design was relatively cautious indicating an incrementalist bias or a prudent reluctance to jeopardizing the decentralized governance structure depending on your viewpoint.

Norwegian Case[3]

General description

«Free choice» of hospital was introduced on the public agenda much later than in Denmark and it was also a more incremental implementation process even if the final solution is more radical than in Denmark. The debate started in the beginning of 1990s and in 1994 an experiment started in two regions with free choice of hospital in a restricted area. In the beginning the discussion mainly concerned a better waiting list guarantee and how to solve that. Free choice of hospital was later on also described as solving the dissatisfaction with the so called guest patient agreement, which was supposed to solve capacity problems in counties. Still after introducing guest patient agreement there were different waiting times depending on what county the patient belong to[4].

In January, 2001 free choice of hospital was implemented in the whole country (Pasientrettighetsloven LOV Ot prp nr 12 (1998–99)). It was included in the patients´ rights act together with rights to assessment, and second opinion and rights to

[3] The following analysis is based on parliamentary debates on waitinglists and patients´rights act and systematic reviews of newspapers and professional journals from the beginning of 1990s to 2003. Newspapers and professional journals used are Aftenposten, Dagens medisin and Den norske lægeforeningens tidskrift.

[4] St.meld nr. 44 (1995–96) Ventetidsgarantien – kriterier og finansiering. Ref. 1993–96 (antallet brudd på ventetidsgarantien mer enn tredoblet – flere brudd på ventetidsgarantien). St.meld. nr. 50 (1993–94), Brudd på foreskriftene (Statens helsetilsyn 1999), Forskjeller i hvordan helsearbeiderne har praktisert foreskriftene (Kristoffersen og Piene 1997, Jørgensen og Eldøen 1996).

treatment, right to involvement and information, right to approval to health help, right to take part in medical journal, special rights for children and patient representatives agreement. In other words it was not only free choice of hospital that was introduced but a whole package of patient rights.

The political decision process was not as in Denmark driven by pragmatic compromises and concern for the decentralized democratic management. Instead Norway implemented a parallel reform, the so called Hospital reform at almost the same time as implementing the patients' rights act which not was aiming at decentralized democratic management. The Hospital reform was implemented January, 2002 and changed the legislative and practical infrastructure of the whole specialist care (hospital sector) (HD-Ot.prp.nr 66 (2000-2001)).. There were three main elements in the reform. First, central governments took over responsibility for all specialist care from the county. Second, five regional health enterprises were established covering each of the five health regions. The regional health enterprises have both the statutory responsible for ensuring the provision of health services to inhabitants in their geographical area, and each regional health enterprise is the owner of most health care providers in its region. To be organized as enterprises means that hospitals no longer will be part of the public administration, but independent legal subjects. Instead of having local politicians each regional enterprise is set up with an executive board appointed by the Ministry of Health Affairs and a general management led by a chief executive officer. The same model applies for health enterprises. The regional board appoints the board at this level. Third, the Minister of Health Affairs, as the general assembly for the regional health enterprises, is responsible for overall general management of specialist care.

The introduction of the Health reform demanded a change in the patents´rights act. Implementing the Hospital reform made the term «public hospital» unclear (HD-Ot.prp. nr. 63, 2002–2003, ch 4) while a hospital not is the same as a health enterprise which can include several hospitals. According to the patients´ rights act only public hospitals was included in the choice possibility, and not non-for profit or commercial private providers. Practically this has been solved by redefine «public hospitals» to hospitals having an agreement with regional health enterprises, which also can be private providers (non-for profit and commercial). Formally the act was changed in 2004 (HD - Ot.prp.nr 63, (2002-2003)). The change concerned that both that patients have a right to choose private hospitals that are included in the public health plan and the right to necessary help within an individual time limit. There will are now a central organization helping patients to get help in Norway or abroad, which indicate that the process to get help abroad will be easier.

Dominating arguments

The main argument for implementing free choice of hospital in Norway was similar to Denmark, namely an improved match between resources and demand to reduce waiting lists. Although, the base for the arguments differ compared to Denmark. In Norway it was based on the critic against the counties for not being able to give the Norwegian population treatment in order to their rights. Even if patients had both guest patient agreements and waiting list guarantees it did not work in a satisfactory manner. In order

to improve patients' conditions the sitting political committee wanted the waiting list guarantee to be cancelled and the patients' rights secured by a new act – the patients' rights act. In addition the committee in the end also discussed that the choice should include hospitals abroad and not only inside the country (HD-Ot.prp. nr. 12 (1998–99)). Arguments for using hospitals abroad are expressed like a threat for the counties in order to force them to take their responsibility.

Free choice of hospital was not often discussed separately from patients' rights in the political debate in Norway, but rather as one part of many in the new act of patients' rights. The representatives from the counties did not react or question the patients' rights act even if free choice of hospital meant a more problematic planning situation. The lack of reaction to free choice of hospital has to be understood in light of other debates during this period. Together with the debate of patients' rights also an «attachment» debate started, that is who should be the owner of the hospitals. There was an increased frustration from the government of how counties handled the health care sector and the role of counties was questioned. There was frustration with the fact that waiting lists kept growing in spite of budget increases, increased number of patient treatments and increased amount of health personal. Lack of skilled personnel and problems with using available resources at other hospitals could provide partial explanations for this paradox. However, this was not sufficient to reduce the political attention. In the white Paper on Health of 1994, (St.meld. nr. 50 (1993–94)) the present minority Labor government invited the parliament to discuss several major health issues, there among strengthening of patients' rights, ownership of hospital, cooperation and division of labor within five health regions and financing system. So the Norwegian debate on changes in health care sector was rather complex during the end of 1990s.

The approach of implementing patients' rights act developed the opposite way in Norway compared to Denmark. From the beginning the act was discussed as a rather caution approach. In the suggestion from 1994 the act had limitations meaning that choice only was meant inside the region or in some cases the closest region in addition, while the final suggestion included the whole country. The discussion at the end even concerned free choice of hospital abroad. This can be understood as the liberal ideas taking over, but the debate still mainly concerned a more practical way of solving coordination problems in health care sector and how to shorten waiting lists. For example did Conservative Party together with right wing Progressive Party try to include private hospital in the choice opportunity, but that was denied which can be understood as they did not want to emphasize creating a quasi-marked but a good coordination between public hospitals.

This practical approach can maybe also be understood in light of the situation in Norway during late 1990s. The economy was running at max capacity and it created problems with lack of working population. This meant that sick individuals from the working population were a society problem. In order to handle this problem not only free choice of hospital was implemented but also «substitution of sick leave for health services». The idea was to get working population quick back to work again by sending them abroad for treatment. Another service that was implemented (as an experiment) was the so called, abroad billion. It was a temporary service to be able to both shorten waiting lists and to put a pressure on the Norwegian hospitals to increase production.

Even if these resources mainly were used by patient with easy diseases (like breast reduction and varicose veins) these resources are now allocated directly to the regional health enterprises in order to use for patient treatment either in the region or in Norway or abroad. All in all this pinpoint the practical approach in shortening waiting lists.

Even if the approach of the argumentation was practical there were also more liberal arguments used. Use of private hospitals was not commonly used as an argument but the conservative (mainly right-wing Progressive Party) argued that in order to be able to offer the population larger capacity it would be a good solution to include private providers. They also mentioned the competition argument and both the Conservative Party and right-wing Progressive Party tried to include private provider in free choice of hospital. They did not succeed with that during that time, but later on in 2001 private providers became included in the public health plans. This means that the regional boards today are responsible for procuring health services for the population in the region, not only via their own hospitals but also from private specialists, private laboratories and private hospitals.

Policy processes

The process leading to the introduction of choice in Norway has elements that can be interpreted in both rational actor and garbage can perspectives. In a rational actor perspective it can be observed that national politicians from both sides of the political spectrum supported the idea of choice at the end of 1990s. This was probable based on the increased critique against the counties and how they handled health care sector. Some areas that were explicitly mentioned in the debate were increased waiting lists and bad resource allocation between counties and also between hospitals. The arguments in the end were mainly based on rhetoric of patients' rights and because of the slow implementation process (starting with small successful experiments) there were not anxiety at the national level about the consequences of the reform.

In a rational actor perspective this could indicate that national politicians were serious about reducing waiting lists and use the free capacity in the sector in a better way. They therefore chose a solution that introduced choice, but not as a market mechanism but rather as a patient right. In advance of and together with patients' right act several other activities where introduced (substitution of sick leave for health services and abroad billion) which can be understood as a serious attempt to reduce waiting lists. The main interest for the national politicians seems to have been to create a pressure on the county or the regions to deal with the growing waiting lists. This becomes even clearer in the attachment debate starting with the white paper on Health of 1994, where both ownership of hospital and patients' rights comes on the political agenda. The same year in 1994 did also the free choice of hospital experiment started in a few regions. The arguments for making this experiment concerned how it would be possible to give patients more freedom and better service, and in addition starting to modify the rules in the so called guest patient agreement. The guest patient agreement had existed for a while and was criticized for not allowing patients to choose and as a consequence the coordination between counties did not work well. The Government

meant that there were counties that preferred to have patients on waiting lists instead of sending them to other counties.

The critique against the counties was strong and the government argued that counties prioritized other sectors at expense of the specialized medicine (hospitals). The government had tried to put a pressure on the counties to change this, for example by introducing DRG-based funding in 1997. The construction of the activity based funding was based on DRG-points and in addition the DRG-refunding was lower then marginal cost so the county had to contribute to the costs of increased production. This construction of activity based funding made it profitable for the counties to allocate resources to the hospitals instead of other sectors (like school or culture) because they only had to pay a small part of the costs for increased production. Even this construction of activity based funding did not lead to neither more cost-efficient health care nor shorter waiting list. The counties had the responsibility for specialist care while the government got the bill (due to deficits).

County levels politicians did not criticize the suggestion with free choice of hospital. As mentioned earlier the critique against the county was so severe that the government questioned to have counties as responsible owners of the hospitals. This means that the debate about changing ownership from counties to the state was at the same period as the end of the debate of introducing patients' rights act. One explanation, for why there were so little reactions from the county level politicians, is that they were more focused on the more fundamental discussion of the survival of the county institution.

Patients advocacy groups kept a low profile. Only heart and lung diseases organization commented that the right also had to include non-for-profit and private hospitals (for example a private hospital with a good reputation for heart diseases). Professional groups were mainly positive. The critique that came concerning free choice of hospital was from the northern parts of Norway, where they argued that a consequence could be that patients would prefer to choose hospitals in larger cities (like Bergen or Oslo), which would make it difficult to maintain a high quality service within specialized medicine in the northern parts of Norway. Further on the psychiatric care organizations raised critique. They argued that it did not suite patients within psychiatric care to choose hospital because their illness special characteristic.

The end result can be seen as rational in the sense that it addressed a perceived problem with too long waiting lists and large differences between regions. However, when viewing the process at a broader system level the garbage can perspective becomes a relevant supplement. As already mentioned the «garbage can» or «multiple streams» perspective operates with three different streams that occasionally combine to create windows of opportunity for decision making. The problem stream in the Norwegian case can be understood as for example problems such as waiting lists kept growing in spite of budget increases, increased number of patient treatments and increased amount of health personal. The policy or solution stream contains not as in Denmark of NPM type ideas but rather of a politicians eager to show power of action in doing something to change the growing problems in health care sector. Finally the third stream (the politics stream), which is characterized by in particular instances create opportunities for policy decisions that extend beyond incremental change. In the Norwegian case it seems like the radical Health care reform debate, that maybe can be

understood as an external shock to the sector, opened up a window where a more radical solution for free choice became a reality. This created a parliamentary situation where a broad coalition of parties was willing to support the idea. But the actual effects do not seem to be that radical, which also can be explained in light of the Health reform. That reform is emphasizing the planning function at the regional level which makes it difficult for information about free choice of hospital to reach the population. There are also other kind of bureaucratic obstacles that make the choice difficult, but that will not be discussed in this paper.

Discussion and conclusions

In this section we will draw on the conclusions from the case to present answers to two main questions namely why was choice introduced in the decentralized public health care systems in Denmark and Norway? And how can we interpret the differences in timing, arguments and design of the legislation? In order to answer these questions we use the theoretical platform based on a rational perspective and a garbage can perspective. Finally, we discuss the development in the two countries from an exit-voice perspective in order to contribute to a better understanding of health policy making in public health care systems.

As indicated in the introduction choice is a concept that conflicts with the tradition for decentralized public planning of health care in Scandinavia. The introduction of this concept thus represents a new turn, or perhaps even the beginning of a more fundamental break of the previous path in health policy making in Denmark and Norway. This raises the question of why the concept was introduced.

The two case presentations indicate similar macro level explanations, namely that health policy has risen to the top of the policy agenda in both countries, and that national level politicians could see benefits in the scheme in terms of popular support and in terms of challenging the power of the decentralized authorities in order to take back some of the control of health policy making. In both cases choice was linked to perceived lacks in service and flexibility. This indicates that the introduction of choice was also linked to broader cultural level changes in the perceptions of linkages between citizens and the public sector as service provider. Modern citizens/patients were regarded as more alert and more demanding and they have come to expect choice and service orientation from encounters with the private service industry. This poses challenges for public planning systems that must find new ways of combining the typically conflicting goals of macro economic control and choice/flexibility in the system.

There are thus a number of underlying trends and factors that are similar in the two cases and can provide explanations for the introduction of choice. However, the two cases also showed a number of differences in timing, rhetoric and contents of the legislation. The following figure illustrates the main differences.

Table 1. Differences between Denmark and Norway in arguments and policy processes

	Denmark	Norway
Policy timing	1992 (early)	2001 (late)
Policy solution	Cautious	Radical
Act	General Health Act that stands alone	Patients´ rights act linked to comprehensive structural reform
Main arguments for	Markets and patient rights Increased flexibility and service Evening out waiting lists by better allocation of resources	Strengthen patients rights Evening out waiting lists by better allocation of resources
Primary proponents	Coalition of national level politicians from Liberals to Social Democrats. Patient groups and media. Some medical professionals.	Coalition of national level politicians from Liberals to Social Democrats. Patient groups and media. Some medical professionals
Main arguments against	Jeopardizes expenditure control. Risk of technological «arms race» Undermines democratic planning capacity at decentralized levels	Undermines the advanced medicine in the northern parts of Norway Not suitable for psychiatric patients

How can we interpret the differences?

First timing is different, the general NPM trend in the public sector seems to have been introduced earlier and relatively stronger in Denmark than in Norway at least in the core welfare state areas. This can be explained by a number of factors: the economic crisis in Denmark in the 1980s created a climate that was favorable to NPM type ideas for scaling back the public sector. This can be seen in how the conservative/liberal government acted from 1983 to 1992 by introducing a number of public sector reforms which paved the way for further changes. It seems there was a larger frustration from the national political level over the economic situation in Denmark compared to Norway, which seems natural when considering both the wealth of the Norwegian state and the severity of the economic problems in Denmark at the time.

Even though the timing differs between the countries the rhetoric can after a first glance give a similar impression in the two cases. Also in Norwegian newspapers there were general debates about market forces, customer and free choice in public organizations in spite of the fact that NPM trends are not adapted and implemented much in Norway, especially not in health care organization. Going deeper in to the content of the rhetoric the debate can be understood as a critique of market elements been introduced for example in EU-countries. In Norway it was a more protective politic during this period. In Denmark on the other hand the market rhetoric and the

actions seems to go more hand in hand, although health care was never at the forefront of NPM changes in the public sector.

The historical context for introducing choice thus differs between the two countries. When Norway introduced free choice the general rhetoric in Western countries had changed focusing more on rights instead of markets (Nordgren 2003). While Denmark was implementing free choice during a period of mainly market rhetoric Norway was implementing it in a period of two competing rhetoric's – market and rights. However, the market rhetoric did not play out in full force in Denmark as dominant actors were concerned about the potential loss of planning capacity and financial control over health care. The policy was therefore designed to accommodate the market rhetoric while not seriously dismantling the regional planning system that had proven relatively successful in securing macroeconomic goals of expenditure control. The result was a somewhat restricted choice model and a preservation of the regional democratic system. The period since the introduction of choice has represented many challenges in the attempts to overcome the dilemmas of introducing choice and activity based payment in a regional planning system. One of the outcomes has been increasing pressure for structural reform in order to create larger regional units.

When it comes to contents of legislation there are again differences between the two countries. Denmark implements free choice of hospital as part of the general health sector act while Norway has included it in the patients´ rights act. This could indicate that the public opinion in Denmark was in general more in favor of market solutions in health care. Other differences connected to content was that choice was introduced in regards to cross county movements in Denmark, while choice within the counties was already largely implemented by the counties. In Norway the legislation introduces choice both within and between counties, i.e. it was non existing before (even if it was possible for the counties to send patients between counties the patient had not had any rights to chose hospital). In Denmark there are restrictions in terms of gaining access to highly specialized hospital departments, while in Norway the patient now have the right to chose any hospital in Norway with agreement with the regional health enterprises as long as they have a remiss to that department In Denmark private for profit treatment facilities are not included, while they are in Norway if the private provider have an agreement with regional health enterprises. The only limitation in the Norwegian free choice of hospital is that the patients can not chose level of treatment, emergence treatment and psychiatric care for children is excluded.

All in all these factors meant that the Danish national level politicians were faster in adopting this fashionable and seemingly popular idea of choice. However, the design and implementation of choice in Denmark also shows that concern for control of macro level expenditures for health care remained strong in Denmark and that the power of the decentralized interests was stronger in Denmark when choice was introduced than in Norway in 2001. This led to a relatively cautious and hesitant implementation where concerns for county level planning and rationing capabilities have played a significant role. Norway has been more willing to experiment with structural reforms that can support a stronger role for choice as a tool for reconfiguring the system – to create the quasi-market. Norway was earlier than Denmark in introducing DRG based payments for choice patients (2000 in Denmark, 1997 in

Norway) and the overall level of activity based financing has been higher in Norway for a number of years (10% or less in Denmark until 2002 and 60% in Norway – until 2003). The recent structural reform in Norway has also created a situation where hospitals gain a more independent status and thus are in a stronger position to compete for patients.

The end result in both countries can be seen as rational in the sense that it addressed a perceived problem among citizens and patients. But the decision process also appeared to have garbage can like elements in the sense that choice quickly become a fashionable solution which was linked to a number of different types of problems in the sector such as waiting times, uneven distribution of resources, limited power to patients, perceived lacks in efficiency, service and quality. There were no systematic investigations of the realistic potential of choice in solving these many different problems.

You can thus argue that the general consensus on the fashionable idea of choice opened a political window for action and that national politicians chose to use this window. However, in the Danish case they were not willing to make a more radical decision of introducing strong incentives and/or more independent providers. The scope for decision making narrowed as the idea was processed through the political system and the arguments and interests of regional actors gained influence. This meant that the end result was a more cautious version of the choice scheme that fits better with the arguments regarding patient rights, than with radical market arguments. In Norway the window for decision opened later than in Denmark, but decisions were more radical as choice was linked to a more general structural reform dismantling the democratic regional governance level (fylkene).

In exit-voice terms it is difficult to see that Denmark is shifting radically from voice to exit. A better way of characterizing the situation is to say that there is a new and not always happy combination of choice and exit elements in the system as regional democratic structures are maintained while the economic and planning consequences of cross regional choice are gradually increasing.

In Norway we can see the same narrowing, but not as a consequence of a limited version of patients choice, but as a reaction from the government being vague in which direction the change is moving, since there is both a decentralized move aiming at increased influence by users and a centralized move aiming at increased central control and more use of national standards and guidelines. What role will the regional health enterprise have in the future? It is unclear if they should have the role as having the statutory responsibility for ensuring the provision of health services to inhabitants in their geographical area (a concern model), or if they should cultivate their role as the owner of the health care provider (as in a purchaser-provider model).

At the moment they are not acting as a provider in a market oriented way they act more as a concern emphasizing the planning function. This means that possibility to choose decrease inside the region while they are changing strategy to more specialization within the region. In exit-voice terms voice is reduced by centralizing politicians because the population has no one to turn to in order to articulate their interests or protests. Exit, on the other hand is also reduced in the sense that choice opportunity is reduced by creating fewer possible entities to chose.

Perspectives for future developments

The introduction of choice and the subsequent adjustments of the health care structure in the two countries raise a number of questions for the future of health care in Scandinavia. Planning capacity and decentralized democratic control have long been important factors in the Scandinavian welfare systems. Choice challenges these concepts by restraining the planning and rationing capacity at regional levels. It thus introduces new rules of the health policy game in the two countries. The important question is how the different actors in the system have reacted to the change. How has health care providers changed their perceptions and strategies? Can we identify major changes to the supply side of health care? On the other hand how have patients and referring doctors reacted to choice? Are they in fact exercising the options and what are the consequences in terms of service and quality levels? Have waiting times come down and is there sufficient transparency to actively use choice? What are the consequences in terms of equity and access to health care? These and many other questions will be addressed in two separate papers comparing the demand and supply side effects of the implementation of choice in Scandinavian health care systems.

The outcomes of the reforms will be determined in the ongoing struggles for institutional design in the two health care sectors. As illustrated in this article the tension and power relations between central and regional levels and the historical policy context will be important determinants in the process.

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