Taking Power from Knowledge

A Theoretical Framework for the Study of Two Public Sector Reforms

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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

The paper presents a theoretical framework for studying reforms and organizational change; 1) change as the product of reformers' intentions, 2) change in institutionalized norms and habits and 3) change as a consequence of strategic maneuvering. These perspectives highlight various kinds of actor constellations and reform processes that may facilitate or hamper regime change. We make use of such perspectives in an analysis and tentative comparison of recent reforms of the hospital sector and of higher education in Norway. A common characteristic of the two reforms is that they aim at regime change and increased outside control of knowledge based occupations. The prospects for regime change is seen in the ambitions to move away from *political–professional regimes* in which professional communities and political hierarchies are predominant towards a regime where both the state and the market actors (or models) may play stronger roles. The basic idea in both cases is that regime change should promote new policy content in order to improve quality and efficiency and to serve patients and students. The evidence so far suggests that the relationship between regime characteristics and policy content is quite loose, however. Whereas the hospital sector seems to experience regime change without (significant) policy change, the higher education sector may be headed for policy change without regime change.

Sammendrag

Notatet introduserer tre perspektiver som kan brukes til å studere organisasjonsendring og reformer, 1) endring som konsekvens av planlegging og iverksetting av reformintensjoner, 2) endring som institusjonell endring, dvs. framvekst av nye normer og vaner og 3) endring som konsekvens av strategisk manøvrering. Disse perspektivene bringer fokus på ulike typer drivkrefter som kan tenkes å fremme og motvirke radikale endringer. Med dette utgangspunktet presentes en analyse av to store reformer i norsk offentlig sektor; eierskapsreformen i sykehusene og kvalitetsreformen i høyere utdanning. Et fellestrekk er at ambisjonsnivået er høyt; ikke bare skal det skje store endringer i organisasjonsstrukturen men også i politikkens innhold. De profesjonelle gruppene skal i mindre grad få styre seg selv, makten til å bestemme over tjenesteproduksjonen skal flyttes fra de profesjonelle til bredere samfunnsinteresser og brukerne av tjenestene. Kvalitetsheving er det sentrale målet i høyere utdanning, mens ambisjonene for helsevesenet er at det skal bli mer pasientorientert og effektivt. For å oppnå dette trengs det regimeendring, dvs at det skal slippes til nye aktører, samtidig som holdningene og styringsstrukturen også skal endres. Det er for tidlig å evaluere reformene, men erfaringene så langt tyder på at sammenhengen mellom organisasjonsregime og politikkens innhold er nokså løs. Mens sykehus-sektoren er preget av regime-skifte uten at politikken endres vesentlig, ser det ut som høyere utdanning er i ferd med å bli reformert innholdsmessig uten regime-endring.

Introduction

The objective of this paper is to develop a conceptual approach and tentatively analyze two comprehensive public sector reforms of the hospital sector and of higher education in Norway. Both reforms aim at regime change. If we look at the main policy documents it appears that policy makers have assumed that regime change constitute a necessary condition for goal attainment. A common characteristic of the two reforms is the attempt to bring knowledge based occupations – the medical profession and other health professionals in the hospital sector, and the academic profession in higher education – under better outside control, both political control by the central government and consumer control by the users of the services (be it patients, students or consumers). Thus improved political steering, more efficient organization – including introduction of market mechanisms – and better institutional management are expected to result in higher quality health care and more empowered patients. Similarly regime change is considered to be conducive to better learning processes and education for students in higher education.

Although it may be quite clear what kind of regime politicians want to leave behind, it is not equally clear what change they are aiming at. In order to better analyze political priorities, we shall therefore first present and discuss the regime concept applied in this analysis. Next we give a brief description of the main reform elements in the two sectors, and point out the main features of the regime changes that policy makers hope to achieve. Then we formulate assumptions about the reform process based on a number different theoretical perspectives focusing on various factors that may drive and shape the reform process. The three perspectives – rational planning under conditions of bounded rationality, bureaucratic rule following and political games – point at three different kinds of drivers of reform processes that may facilitate or hamper regime change in various ways. By using different perspectives we address three broad classes of ideas about political reforms and organizational change: change as the product of reformers' intentions, of institutionalized norms and habits and of strategic maneuvering by actors involved in and affected by the reforms. The purpose is not to test alternative mutually excluding hypotheses entailed by the perspectives about likely reform outcomes and their causes. Neither is it an attempt to demonstrate in the spirit of Allison (1971) how different conceptual lenses produce different, although equally valid accounts of the reform process. Our purpose is based on the assumption that the three perspectives represent major drivers that are likely to affect complex reform processes and they are therefore all needed to understand the dynamics of the processes. Thus the focus is as much on how the drivers interact as on the effect of each individual driver.

Regime change

Standard definitions of 'regime' share a double meaning. They usually refer both to social structures like a form of government and a constellation of actors that constitute a specific government in power. Simply put, a regime may therefore be a group of actors and a set of rules.[1] However, we share Weber's (1978) idea that lest it be coercive or manipulative, power needs to be based on shared beliefs in its legitimacy by the governing and the governed. Belief systems therefore are the third element in our regime concept.

The following analysis of regimes shall deal with how power is wielded, conflicts are handled and agreements made under a given set of rules and actor constellations. Furthermore we shall focus on how these social relations are affected when actors and/or rules change. We shall take as our point of departure that public service sectors such as education, health care and social services have their particular forms of variation. These variations are based on the very simple notion that the regimes in principle find themselves within a field of tension constituted by three different social relations into which decision makers enter and that are crucial in determining power relationships and rules of the game within the organization (Bleiklie 1997). In order to give an overview of this approach we first present a typology of public sector regimes based on which actors are most influential on organizational decisions.

First, public service provision takes place in organizations where a basic characteristic is that decisions are made within a hierarchical order and where organization members are oriented towards rules, like they have been described by Peter Blau in his classical study of an American employment agency (Blau 1963). We may call this kind of organizations for *service hierarchies*. An apt example is made by social insurance services which are distributed according to relatively clear cut rules and where the interpretation and application of general rules occupy a central position in the decision making process (Solheim 1992). In public hospitals and universities this logic entails that the fact that they are part of the civil service becomes prominent. As rules and regulations are formulated by politicians and administrative superiors, these are the dominant actors in defining the mission and operation of the organization.

Secondly, the growth of public services (paralleled by the emergence of the modern service economy) in the areas of health, social services and education constitute a significant development of modern welfare states during the last fifty years. This was a field of public activity that was characterized by professions and tended to be organized in a way that departs form our standard image of public bureaucracies (Esping-Andersen 1990, Ramsøy and Kjølsrød 1986). Rather than being governed by rules within the framework of hierarchical organizations, decisions concerning service provision are governed by communities of professionals or by various professional groups that compete and bargain among themselves about the distribution of resources

[1] Webster American Heritage Dictionary lists the following definitions of 'regime': 1 a) A form of government: a fascist regime. b) A government in power; administration: suffered under the new regime. 2. A prevailing social system or pattern. 3. The period during which a particular administration or system prevails. 4. A regulated system, as of diet and exercise; a regimen (Webster 2000).

and authority within the organization. Professional *service communities* are typical of modern health and education institutions in which the content of the services – whether it be diagnosing, planning and execution of treatment programs or curriculum planning and the execution of teaching programs – is determined by professionals (Abbott 1988, Bleiklie 1997, Johnson 1972, Løchen 1985, Rubinstein and Lasswell 1966).

Thirdly public service providing organizations enter into relationships with more or less clearly delineated groups of users. The users may influence decision making in various ways. One kind of service providing organization has been dubbed «street level bureaucracy» by Michael Lipsky (1976, 1980). Street level bureaucracies are characterized by the fact that the relationship between service provider and users (clients, customers, students, patients) of the service is extensive. Service providers have on the other hand relatively little contact with their superiors or colleagues, at the same time as they enjoy considerable discretion in their decision making. Street level bureaucracy is a kind of organization that distributes services to clients who often have few resources and no alternative ways of obtaining access to vital services such as economic support, housing or employment. Social workers, teachers and policemen are typical representatives of street level bureaucrats.

To the extent that decisions about services are made during the interaction between service providers and users, the outcome will depend on the interests and resources at the disposal of the parties involved and what strategies they follow. In the terms of Hirschman (1970) the only way in which they can wield power, therefore, is by using *voice*, i.e. some kind of political or social pressure, and the interaction between users and service providers is often characterized by interest based struggle and conflicts (Bleiklie 1997, Brown 1981, Offerdal 1986, Prottas 1979). The alternative form of power is *exit*, i.e. a situation in which power is wielded through consumer choice, and where dissatisfied users express their concern and try to obtain better services by leaving their current service provider and seek a new one. This kind of service relationship is typically associated with non-public services operating on the market. However, since the 1980s public authorities in Western countries have tried to introduce and experiment with quasi-market mechanisms by outsourcing, use of vouchers or other mechanisms for increasing competition between service providers and enhancing consumer choice and exit opportunities for users.

This move has been propelled by an ideological shift regarding how public administration in general and public services in particular ought to be organized as well as by new ideas about the organization of private enterprises in a service and knowledge based economy – both of which emphasized a strengthened and more active consumer orientation than previously (Myklebust 2001, Pollitt 1993). Whether we talk about street level bureaucracies or modern service industries a core idea is that service quality to a large extent is determined in the process of interaction between service provider and users. The two parties confront one another on a *service arena* where decisions service providers make at least in principle are affected by what opportunities users have to use voice and exit options and how they exercise those options. Although it is difficult to imagine a pure market or consumer dominated regime, its position as an ideal has been strengthened as part of the general strengthening of neo-liberalist ideals in public

services and increased the attention of public services to what they perceive as consumer needs.

The purpose of this typology is to help conceptualize how different service ideals, actor constellations and rules of the game may dominate different parts of the public service providing apparatus. Furthermore it is meant to help identify service ideals that have dominated in different historical periods and represented shifting goals that policy makers have strived to achieve.

The service ideal of the modern state as it gradually emerged from the 17th century was an emerging ideal based on classic bureaucratic norms, in which reliability and predictability were main concerns. Therefore, bureaucratic norms as they have been conceptualized by Max Weber (1978), constituted a dominant ideal, although there has always been a tension in modern bureaucracies between 'the rule of law' and 'the rule of experts'. Certain areas of public activity, such as public hospitals and public universities have been the domain of academic professions since their establishment during the 19th century. If we take the first decades after the Second World War as a starting point these two public sectors have been dominated by service communities, as surgeons dominated hospitals and professors dominated higher education institutions (Clark 1987, Freidson 1970, Scott et al. 2000, Starr 1982). Furthermore when formulating policy proposals policy makers solicited and listened to the advice of professionals. Finally professionals enjoyed a high level of trust and «expert» judgment tended to be respected as one that was based on scientific principles and therefore not steeped in self-interest. Since then several developments have contributed to the current policy of regime change in the two sectors.

From the 1970s on this situation started to change. As hospitals grew and became more complex, new groups of highly educated health care professionals entered the hospitals, and traditional health professions such as nurses, were better educated than before. In universities the group of lecturers and associate professors grew rapidly and soon became the most numerous group of permanently employed academic staff.[2] Both hospitals and universities were filled up by highly qualified personnel with little influence over their working conditions. Medical as well as academic establishments were criticized for being authoritarian, arrogant and unwilling to make their institutions more democratic. Gradually therefore, doctors had to share power with nurses and other health professionals, and professors with other academic staff, administrators, technical staff and students. Although professionals still dominated the institutions, power had become more dispersed, a wider array of professional occupations as well as non-professional employees and students were granted representation on governing bodies. This was the outcome of the drive for democratization of existing regimes that affected both health care and higher education during the 1970s. However, criticism of the professional regimes did not stop there.

Since the 1980s steep growth in both sectors, increasing political salience, rising costs and perceived inefficiency have further contributed to heavy criticism of health

[2] University staff is permanently hired as civil servants in what might be considered a rough parallel to the American tenure system.

professionals and academics. Whereas health professionals have been criticized for being responsible for many of the problems inflicting the hospitals such as exploding costs and long waiting periods before admission for non-emergency procedures, academics have been criticized as responsible for making their universities into ivory towers unable to meet society's need for relevant education and useful research without much sensitivity for the needs of society, students or patients. In these complaints is contained both a dissatisfaction with accountability and failure to control rising costs (particularly in the hospital sector) as well as with an inability to respond to the needs and concerns of the users of the services. Behind this criticism lies a fundamental shift in the trust enjoyed by professionals and academics. As the neo-liberal criticism, focusing on efficiency and consumer orientation was layered on top of the previous wave of democratic criticism; the legitimacy of professionals has been steadily weakened. From being regarded as servants of the greater good: representatives of knowledge who promoted the welfare of their users or of society at large, they now came to be regarded as members of interest groups that tended to exploit the needs of their users in order to promote their own particular economic gain.

We interpret the present reforms as attempts at establishing new regimes in the Norwegian hospital and higher education sectors. The purpose of the regime change is to pull 'power away from knowledge', move the control or influence over the sectors away from professionals and achieve two objectives: a) better political control in terms of accountability and quality, b) greater responsiveness to the needs of users and greater user influence over institutions. In both sectors it seems clear that formal changes have been undertaken that are consistent with this ambition. However, it is not equally clear in which direction regime change is heading, since there is both *a decentralizing move* aiming at increased influence by users and *a centralizing move* aiming at increased central government control and more use of national standards and guidelines. In the next section we shall outline the reforms in the two sectors in more detail before we move on to analyzing the reform processes.

The Reforms

Challenges and solutions in the health care sector

During the last years, health authorities in Norway and many other OECD-countries have been eager to initiate reforms. The Norwegian government has introduced several reforms during the last five years: new management systems that affect the relation between levels of government, new funding systems for hospitals and physicians outside hospitals, as well as patient contributions in a system where services used to be free.

In its country report on the Norwegian economy 1998, OECD featured the health care system and the need for reform. The challenges were summarized as follows: acute shortage suggested by long waiting lists for hospital admission and the lack of physicians and other medical staff; the need to strike a balance between the requirements of a cost-

efficient health care system on the one hand and the ambition to maintain a full-fledged health service in even the remotest parts of the country on the other; the risk of major expenditure increases in the future (OECD 1998).

To meet these challenges, several reforms have been introduced, ranging from introduction of activity-based funding of somatic hospitals in 1997, via the establishment of five regional health enterprises in 2002 (Ot.prp. nr. 66 2000–2001) and the introduction of a patient rights legislation including the right to «free hospital choice» in 2001 (Ot.prp. nr. 12 (1998–99). Below the two most recent reforms are described.

The patient rights act was introduced in January 1 2001 (Ot.prp. nr. 12 (1998–99), and the act will probably be revised in order to further enhance patient rights in the near future. One part of the act concerns patients' right to choose provider, which grants patients the right to choose where he or she wants to be treated and thus create competition between hospitals.

The Hospital reform, which was introduced 1 January 2002, transferred responsibility for public hospitals from the counties to the central government. Five regional health enterprises have been established, which in turn have organized hospitals under local health enterprises. These enterprises are of varying size and geographical span where some comprise just one hospital, while others organize hospitals as divisions under the health enterprise.

The diversity of reforms chosen reflects the variety of goals in Norwegian health policy and the country-specific characteristics of the health care system. The reform initiatives include, simultaneously, both increased competition and reinforced planning. As planning and competition easily may be considered as conflicting policies, the challenge is to make these two elements work together.

Establishing state owned health enterprises may be regarded as a tool with which the state may strengthen its planning role as owner and manager, yet by seeking to strengthen patient rights, it has simultaneously emphasized patients' individual rights to receive treatment and their freedom to choose hospital. The Hospital reform and the Patient rights act have the same goal: a more effective and efficient health care sector to the benefit of the patients. However, enablers and focus are different, and there may be tensions, conflicts and paradoxes involved in the two control concepts. For example, regional health enterprises may be forced to take economic and collective responsibility to handle efficiency and equity in health production, and this may be in conflict with individual patient rights.

Challenges and responses in Higher Education

Norwegian universities and state colleges are now engaged in one of the most comprehensive and fundamental reform processes in their history. The Quality reform may prove to break with a Norwegian tradition as careful and conservative reformer in the field of higher education (Bleiklie et al. 2000). The ambitions are impressive. After a period of steep growth during the 1990s, the first decade of the 21st Century shall be

dedicated to flesh out the comprehensive higher education system that was built up with a qualitatively improved content. In its report to Parliament on the proposal the government stated that the goal goes beyond the ambition of creating better higher education institutions. The ambition is to make Norway «a leading nation of knowledge». We shall argue that a break with tradition is possible and that current policies may cause changes that will be far more radical than previous reforms. However, we also argue that both the extent of change and the direction in which it will move depend on a number of conditions that are not yet settled.

The reform that follows up the report of the Mjøs Commission (NOU 14: 2000) and the subsequent Parliamentary proposal (St.meld. nr. 27 (2000–2001)), was formally approved by Parliament on June 12. 2001. The reform got the upbeat name «The Quality Reform». It proposes apparent sweeping changes as to the way in which institutions are managed and organized; introduces a new degree structure that entails a change in the way in which study programs are organized aiming at shortening time to degree and raising completion rates; and intends to internationalize Norwegian higher education in a way that is basically different from previous attempts with the same stated purpose.

The reform thus consists of three main components: 1) *the study program reform* which involves the implementation of the recommendations of the Bologna declaration with the introduction of a new degree structure: the so-called «3+2+3» or «3, 5, 8» system indicating the duration of the bachelor-, masters- and doctoral degree programs. The reform emphasizes the responsibility of the institutions for efficiency and successfulness of the study programs and the need to introduce modern teaching methods, frequent feedback to students, longer teaching semesters and portfolio evaluation instead of traditional lectures and written exams with rather long intervals that dominated particularly in the humanities and social sciences. The main goal is to make the degree studies more efficient by shortening the time of the degree programs and increasing compliance with program schedules and completion of study programs. The reforms aim at making students float more quickly and with more ease through the system. Important tools in this effort are supposed to be introduced, such as contracts between student and institution, organizing coherent study programs, better use of the entire, enlarged academic year, more varied and better adapted teaching methods and more contact with and frequent feedback to students. 2) *Internationalization* aims particularly at increasing mobility of bachelor degree students and to offer a 3 – 6 months' stay abroad for all students who wish to travel. 3) *Organizational changes* concerning the formal status of higher education institutions in relation to central government, leadership structures at all levels within institutions and introduction of an incentive based element in the funding system that puts a heavy emphasis on the efficient production of exams and student credits.

Among these three reform proposals the radical element seems to lie in the degree- or «study» reform which, if it is implemented as promised, will change the curricular, teaching and degree structure as well as student- and teacher roles in fundamental ways. Our preliminary interviews conducted at one university indicate that most teachers and students consider the study program reform to be the essence of the Quality reform. The changes are likely to affect the «free» faculties in particular. The explanation of this

break with the tradition as careful reformer may be that this tradition has been overrun by another Norwegian tradition: that of clever implementer of supranational agreements and decisions. In the effort of introducing a new European degree system, which is the intention of the Bologna declaration of 1999, Norway has been a front-runner if we consider the pace of the reform effort.

One important reform tool is the new funding model that will be described below. It aims at introducing a clearer separation of education and research and emphasizes the role of incentives in promoting quality and efficiency in education and research.

In the recommendation from the parliamentary Committee on ecclesiastic affairs, education and research that prepared the proposal that was submitted to Parliament, the ambitions were reiterated verbally. The committee unequivocally stated that the reform required extra funding, and the committee majority based its estimates on those made previously by the Council of Norwegian universities and colleges (i.e. the national organization of universities and colleges). The estimates said that a budget increase of 1.5 billion NOK (about € 190 million) was needed in a transition period and 1.2 billion NOK on a regular basis after the introduction of the reform. The committee majority also clearly stated that if the reform was implemented without these extra resources, the reform would jeopardize, rather than increase the quality of higher education. These considerations indicate that the effects of the reform so far seem to depend on the extent to which sufficient resources are provided for the new teaching programs. In its 2004 national budget proposal the government increased the higher education grants to a level that, although somewhat less than the institutions had asked for, was considered sufficient by the universities to carry out the reform. By December 2003, this proposal seems likely to be approved by Parliament.

The changes that have been proposed with regard to institutional organization and leadership have until recently been offered far less attention. The committee proposed new legislation that suggested alternative principles for organizing the institutions under the Ministry. A majority proposed that they be organized as public enterprises whereas the minority recommended that they keep their status as «special civil service institutions». Regarding the internal organization a majority wanted appointed leaders and «unified» leadership, whilst a minority wanted to keep the existing arrangement with elected leaders and «dual» leadership, i.e. one elected academic leader and one head of administration.

The Ministry subsequently gave institutions the freedom to choose whether they wanted to retain the «dual» leadership model or introduce a «unitary» leadership model. This might of course be interpreted as an expression of a radical form of liberalism. However, a special commission (the Ryssdal Commission) was named in order to study the matter and produce a joint recommendation on the issue. In connection with the committee work, a public controversy has surfaced in the summer of 2003. It was triggered by a declaration against a legislation that might organize universities as public enterprises that was circulated on the Internet. The controversy raised the issue of potential consequences of the organizational reform and it was been contended that it might jeopardize university autonomy and the freedom of research.

The report was released in September 2003, but the committee was unable to agree on a common recommendation. However, although the majority and minority recommendations are similar to the previous proposals they were modified somewhat. The

most significant modification is that in this case the majority proposed that the institutions be organized as independent foundations rather than as public enterprises. The group of professors that initiated the public controversy is now arguing against the new majority proposal. They have also organized a campaign against the proposal and collected more than 4000 signatures from a majority of Norwegian professors and other academic employees. By late October 2003 the group established «Vox Academica», a forum for information and debate in order to shed light on the implications of the new law if the majority proposal is adopted.

The introduction of the Quality Reform started the fall term of 2002, and the study program reform as well as the internationalization of study programs is scheduled to be fully introduced by the beginning of the fall term 2003. The institutions have complained that the funding they receive fails to meet the requirements of the study program reform and predicted that funding problems will increase in 2004 unless additional grants are provided. However, the budget proposal for 2004 went further than skeptics predicted in meeting the demands for extra funding.

The organization and leadership reform is still not finally determined, however, it is safe to say that the majority proposals contains centralizing as well as decentralizing elements. They propose to strengthen the hand of central government through a more integrated and standardized higher education system and more extensive use of economic incentives in order to boost efficiency of the study programs, emphasizing student numbers, credits production and time to degree. However, they also propose to strengthen institutional autonomy by transferring decisions on a number of matters to the institutions. Yet within institutions, the traditional academic freedom, the autonomy of the individual scholar is sought reduced through stronger external influence on the university boards and stronger institutional leadership to convey that influence throughout the organization. Furthermore, they also look to strengthen the power of students as consumers, emphasizing the importance of student numbers for funding.

What drives the process of public sector reform?

Our approach focuses on the drivers behind the policy process. These drivers do not by themselves predict towards what kind of regime the process is heading, but point to mechanisms through which change occurs. Knowledge of these mechanisms may then form the basis for more precise assumptions about the direction of the reform process. The idea is that actors involved in processes of policy change may be motivated by various factors. Below we have distinguished between three different ideal patterns according to whether the process is driven by: 1) reform plans, 2) rule following based on habits or bureaucratic structures, or 3) political games by which actors engage in self-serving strategic maneuvering based on their perceived interests. The perspectives bear a strong resemblance to Graham Allisons' three decision making models in his famous book about the Cuban missile crisis (Allison 1971). However there are two important differences between the perspectives used here and Allison's models. First, considering

the development of organization theory and theories of public policy over the three last decades our perspectives cover a wider set of theories and models that share some basic assumptions about organizational decision making. Second, the purpose as already indicated, is different in the sense that we are interested in understanding the interaction between the drivers or factors highlighted by the models rather than demonstrating the different stories rendered by the different conceptual lenses of three models.

Rational planning

The outcome of the process may in principle be the result of *a rational plan.* Such a plan entails a combination of goals, norms and incentives that are communicated to, understood and accepted by the actors involved in such a way that it is implemented in accordance with the intentions of policy makers. The assumption on which this ideal rests is that the actors involved somehow are working together within a hierarchical order trying to fulfill general policy goals. New goals may require actors to develop organizational structures and ways of interaction that deviate from what they are accustomed to. Policy goals may express, in a sufficiently unequivocal way, values and aspirations that are shared by the actors. Even if the actors involved do not share policy goals, policies may come with incentives that motivate actors to behaving rationally in terms of policy goals. Theories based on this kind of perspective focus on the future, on internal organizational characteristics and action (Brunsson 2003). They assume that the driving force in reform processes are attempts at pursuing specified goals by using a set of consciously designed means. Processes of reform and change are thus oriented towards future goals and basically driven by the internal processes of choice identifying goals, followed by consciously chosen action strategies in order to achieve them.

Organization literature has pointed to three main limitations on organizational rationality – cognition, complexity and dependency on the environment – that make it difficult for organizations to fulfill ideals of rational planning. Cognitive limitations imply that the organizations have limited information and attention spans, think locally and tend to opt for satisficing rather than perfect solutions (Simon and March 1958). Organizations are complex and with complexity the chances increase that conflicts of interest may arise between subdivisions within the organization. Therefore, goals tend to be quite general and vague because they need to accommodate the interests of actors with diverse and partly conflicting interests (Cyert and March 1963). Furthermore complex reform processes are often «loosely coupled» (Weick 1976), or coupled in ways that are not defined by the means-ends logic assumed by theories of rational action (Brunsson 2003). For instance, actors and policies are not necessarily just focused on the issues that they ostensibly deal with as part of the reform process, but also on processes and issues in other arenas. Although a government may invest much energy in gaining support for a certain policy, it does not necessarily intend to act on it and people who support it as a general program are not necessarily ready to accept the consequences of the same policy if it is implemented. Finally, organizations are dependent on their environment for resources and legitimacy (Cyert and March 1963). This means that a policy reform process does not only turn on the degree to which some clearly designed

policy is implemented, but on negotiations and accommodation with actors who are part of the process as well with actors and circumstances that constitute the environment of the policy process. Consequently their behavior may be affected by outside events that in turn affect the outcome of the process (March and Olsen 1976).

For these reasons reform plans, like the Norwegian hospital and higher education reforms, tend not to be very specific, but require that the actors involved sort out a number of issues. Some of the issues have to do with how actors (institutional leaders) may develop their organizations, introduce new measures and implement policies locally that are consistent with and supportive of national policy goals. Another batch of issues has to do with how interests are affected by reforms and the extent to which the interests of actors that might otherwise thwart reforms are accommodated in the reform process. A third batch of issues has to do with how the policy process is affected by the environment. The fact that the public sectors involved depend on externally generated resources means that they need to enjoy a measure of legitimacy among politicians and the public at large. Finally, complex processes consist of multiple arenas. Actors on the parliamentary arena may have their policy positions on hospital care and higher education shaped by the coalition politics and logrolling as well as by party programs and personal convictions.

Rule following

In organization theory it is commonplace to assume that rational action is limited by the fact that actors are circumscribed by rules and norms e.g. as Standardized Operating Procedures (SOPs) (Allison 1971:67ff). This does not only apply to individual organization members, but also to organizations themselves as parts of a wider social context. New institutionalists have consequently taken the argument further when they emphasize that actors are not only constrained in their choices by their normative environment, their preferences are also shaped by it and they become themselves carriers of normative expectations (March and Olsen 1989, Peters 1999). In bureaucratic processes actors are in a number of ways guided by norms that make them accept and adopt certain routines and preferred modes of action in the face of reform policies. In order to understand their behavior as *bureaucratic rule following* we need to understand how actors let their behavior be guided by and justified in terms of organizational routines and SOPs. From a policy and management perspective, the classical problem associated with reform policies is that routines that are established with a goal oriented intent tend to live a life of their own and become imbued by meaning that gives them an independent value. Policies may thus be considered implemented once new procedures and routines that are assumed to the support the policy aim in question are in place. This observation has a number of implications: First of all in order to be implemented policies must be accepted as legitimate by the major actors and stakeholders involved. Secondly, legitimacy does not depend exclusively on the attractiveness of the policy content, but often as much on the procedures by which it is promoted. Similarly legitimacy is not just a question of how resources are distributed, but also on the symbols and values in terms of which it is justified (Meyer and Rowan 1977). Thirdly,

policy change tend to be slow and piecemeal as new proposals need to be accepted and understood in terms of existing values and symbols.

That routines have a life of their own often becomes evident when existing organizational arrangements and procedures are challenged by reform policies. Performance measurement and detailed governmental regulation may furthermore divert reform efforts that aim at creating new organizational practices (e.g. increase institutional autonomy or enhance accountability) from such efforts and revert to routinized behavior that may be efficient, but not necessarily instrumental in achieving original goals. For example, although the intention of the Hospital reform is to make the new regional and local health corporations more autonomous from government regulation, the new system will easily become marred in detailed government regulation and rigid bureaucratic control within corporations. This tendency may be amplified by interprofessional power struggles and turf wars and subsequent attempts at keeping such conflicts under control. Thus the actors who are supposed to implement the reform become hostages of the organization with its bureaucratic characteristics in which they find themselves.

Political games

The two above perspectives (rational planning and bureaucratic rule following) assume that organizational actors engage in collective activities and that their behavior is affected by collective mechanisms such as plans, rules or bargaining processes. However, there is also the possibility that actors may engage in *political games* in order to reach individual goals that they believe serve their interests (Allison 1971: 147ff). Their actions must be understood as means by which they try to acquire more resources, power or prestige. In order to understand how actors behave in a given policy domain, it is not sufficient to know policy contents in terms of policy aims and means. In addition one needs to know how actors perceive that their interests are affected by a policy and what strategies they apply in order to promote their interests under the conditions set by that policy. From a policy and management perspective, any reform initiative is problematic because of the difficulties associated with predicting how the players perceive new policies and how they react to the policy instruments that are deployed.

Modernizing reforms such as the current reorganizations of the Norwegian hospital and higher education sectors may thus constitute just another arena where established interest groups (professionals, administrators, government bureaucrats, politicians and media) engage in their usual games. In a situation where actors behave cynically in terms of policy goals and where all or at least some actors will be dissatisfied with policy outcomes, strategies are likely to involve attempts at media exploitation, window dressing, and blame games. In such a case one might say that the reform and the organization through which it is sought implemented become hostages to the individual interests and self-serving behavior of the actors.

Two reform processes compared – some assumptions

The three perspectives outlined above point to a number of processes that may be crucial in shaping the reform process and determine its future such as accommodating the interests of major actors through bargaining processes, adaptation to the environment, the ability to legitimize the reforms in terms of existing values and accepted ways of doing things, and the ability to discourage actors from engaging in political games designed to serve individual goals at the expense of those of the organization.

The perspectives are not alternative, but complementary and they highlight different kinds of drivers that may be at work during the reform processes. Norwegian hospitals and universities share certain characteristics that may invite us to assume that reform policies aiming at regime change may face similar challenges, but there are also clear differences between them that make them interesting cases for comparison. Firstly, the core activities in both sectors are carried out by strong knowledge based professional groups that are likely to interpret and value reform proposals in terms of their group interests and values. However, work is organized differently in hospitals and universities and professional associations and unions are organized differently. Professionals in hospitals (physicians, nurses etc.) belong to hierarchically and functionally different groups, and they belong to different professional associations and partly different unions (Berg 1987). University academics on the other hand are horizontally divided in various disciplines, but they fulfill the same functions, teaching and research. Most of them are organized in the same union, and to some extent they are perceived as one profession (Clark 1987, Høstaker 2000).

Secondly, in both sectors there is a tension between two forms of authority – one based in the bureaucratic–administrative hierarchical line of formal authority and the second on professional meritocracy and occupational hierarchies. Yet the main tensions that structure conflicts in the two types of organizations are usually different. In hospitals conflicts between the major professional groups, physicians and nurses, tend to overshadow and shape the tension between administrators and professionals (Berg 1987). In universities on the other hand administrators and academics tend to perceive their institutions as sites where the two groups are engaged in a tug-of-war that constitutes the major conflict dimension within these institutions (Bleiklie et al. 2000).

Thirdly, in both sectors potentially radical reforms are introduced in settings where strong traditions exist that inform actors' beliefs about how the work should be done and how it ought to be organized. Yet the traditions are based on different social values: In hospitals they center on ideas about medical and other forms of professional *authority* that shape the internal division of labor. In universities traditions turn on the value of *autonomy* of academic institutions and individual academics.

Our main argument is that reform processes in the two sectors are likely to be facilitated or hampered by different factors because the social relationships are structured in different ways in terms of organizational arrangements, conflict patterns and value systems.

Based on previous experience we would accordingly expect that the pattern of behavior that is most likely to structure the reform process in the hospital sector is *fragmented interest struggle*. This means that various professional groups are inclined to evaluate the reform proposal in terms of group interests, and they are as likely to feel threatened by other professional groups as by political and administrative leadership. Professionals are likely to focus more on working conditions and wages than on hospital ownership and governing structures per se. Expressions of opposition and discontent have traditionally taken the form of interest struggle and pressure politics with active use of mass media in order to mobilize political support. However, the reform goal is precisely to cope with internal fragmentation, create more transparent organizations with clearer responsibilities and make the new health enterprises into more coherent institutions that are better equipped to operate as actors. Negotiation and conflict resolution are crucial activities in the reform process in order to accommodate the fragmented interests involved and established legitimate corporate leadership. An indication of successful transition to a new regime may be that hospital leadership enjoys more public visibility and professionals less in matters related to hospital administration and funding. But the indication is an ambiguous one and there is always the possibility of less visible resistance in terms of bureaucratic rule following.

As for higher education experience suggest that the reform process is likely to be affected by *symbolic value defense*. University academics are inclined to evaluate reform proposals in terms of real or perceived threats against the value of (personal or institutional) autonomy. Such threats are usually vague, and academics are as likely (maybe more likely) to focus on formal leadership and governing structures as symbols of power that may protect or undermine autonomy, than on how they may affect specific working conditions or wages. Typical expressions of opposition are the staging of public controversies in national media[3], or undermining reforms by ignoring them or translating them into forms that are considered appropriate. Reforms are usually implemented in a decentralized manner were committees of faculty at the operative department level are given considerable leeway to give substance to reforms during the implementation process. A smooth regime transition would be one in which academics trade power for autonomy, accepting the notion that it is difficult to have both.

Shaping hospital reform

In this part we will discuss further how recent reforms in the Norwegian health care sector might play out in light of the three perspectives. In addition to the Hospital reform we shall also consider the impact of the Patients bill of rights in order to get a fuller picture of ongoing hospital reform efforts.

[3] Previous reforms in higher education have all been partly defined by accompanying public controversies: about positivism in 1969, academic excellence in 1988 and Management by objectives in 1989.

The Hospital reform as rational planning

This perspective assumes that process of health care reform may be driven by planning brought about by a response to specific problems in the health care sector. According to this interpretation politicians aided by experts have formulated policy goals and selected means that shall bring the Norwegian health sector from a bureaucratic system characterized by efficiency-problems to a more cost-efficient, consumer-friendly and competitive system. This is a perspective that represents the ideal that may be inferred from the aims of the Hospital Reform and the Patient rights act. We shall therefore point to three different contradictions in the reform that follow from the way it is designed and indicate explanations for the design depending on the balance that will be struck between: a) efficiency and patients' expressed needs, b) the focus on planning within the hospital sector and the need to coordinate between specialized and primary care, c) the creation of monopolies and the goal of competition.

First, considering how the reforms have been formulated they may be interpreted as attempts at achieving efficiency and consumer-orientation through devolution of authority to regional health enterprises, stronger institutional leadership and at the same time increased emphasis on patient rights including patients´ rights to choose provider. The reforms thus appear to introduce two different management principles at the same time – both increased planning by introducing regional enterprises that threaten to become de facto monopolies and increased competition by the extended patient choice.

The outcome of the reforms may depend on the extent to which the sector succeeds in balancing the two reforms and on the ability of the government to avoid involvement in the affairs of the health regions in a way that is not detrimental to reform goals and the legitimacy of the regional health enterprises. Too much emphasis on the planning model implied by the health regions may divert the focus from patient interests and rights. However, if patients' right to choose provider are emphasized too strongly, this may represent a threat against the efficiency as well as the medical quality of health care. If patients emphasize closeness to hospitals and their preferences affect the hospital structure in a region, the sector is likely to consist of relatively many small hospitals. As a consequence the catchment area for patients becomes too small to provide physicians with a sufficient number of patients to provide adequate training in advanced treatment procedures and a lack of advanced medical equipment. This again may result in reduced efficiency, less economy of scale advantages and poorer quality of services.

Secondly, let us now assume that in spite of the obstacles pointed at above, the Hospital reform will succeed in creating a modern, decentralized and efficient organization. This means that the hopes of the Ministry of Health, of more clearly defined responsibilities, which are quoted below from an official document, will be fulfilled:

> «One of the most important initiatives of the reform is that the hospitals will have more clearly defined roles and responsibilities. This is due to the fact that the entities will, as mentioned above, no longer be an integral part of the public administration. Rather they will be organized as enterprises. These enterprises will have their own responsibilities as employers and will be responsible for use of capital. The enterprises will also be responsible for their own finances, with the restriction that they may not go into voluntary liquidation. As sole owner, the

> central government will have unlimited responsibility for and full control of the enterprises.»[4]

However, the reform appears to focus exclusively on regional and local health enterprises as means to achieve its goals. One implication of successful development of a rational organization in the above sense is increased efficiency by increased specialization and coordination within the organization. Hospitals may therefore emerge as production units that get patients through the hospital system with a minimum of time. Provided that the hospitals become efficient, this easily runs into conflict with the idea that health enterprises are supposed to create public goods at an acceptable quality from a patient point of view. This has implied in recent years an increasing emphasis on the needs of the individual patient.

One of the main challenges posed by recent developments in the health care sector – such as shorter lengths of hospital stays, more emergency care and an increasing proportion of patients with chronic diseases – is to create a treatment program that is holistic from the patients' point of view. A crucial question, accordingly, is how hospital care is coordinated with primary health care. The Hospital reform does not seem to deal with such overall coordination problems that nevertheless will surface and affect its chances of success. Although the central government determines much of the legal and financial operating conditions for health services outside hospitals, they are nonetheless run by municipalities. The state has a limited authority to decide how municipalities shall allocate their resources. Therefore, there is always a risk that patients may finish their medical treatment at a hospital and then be denied access to the primary health care services they need (e.g. nursing home). Coordination problems of this nature may therefore lead to well-known efficiency problems where hospitals are forced to retain patients who normally would be sent to a nursing home, or where emphasis on efficient treatment without polyclinical follow up services creates a huge population of «revolving door patients» who occupy a substantial part of hospital capacity.

Third, if the reforms are interpreted as a response to an ambition to pursue not just the goal of efficiency, but also that of competition, it is difficult to understand why effective monopolies were created with the introduction of five health regions. One is easily left with the impression that planning and control have been emphasized rather than the competitive context for local health enterprises that was emphasized in policy documents.

Considered as rational planning there are features of the reform that are difficult to understand. However if one takes into account that the reform needs to win the support or at least compliance in a complex environment in which many different actors and interests are involved, they are easier to understand as attempts at easing negotiations with significant actors and adaptation to conflicting demands e.g. from professional groups, administrators and politicians. Thus the observation that not being too rational in a narrow sense are in fact quite smart may turn out to be corroborated by this case as

[4] The Norwegian hospital reform – Central government assumptions responsibility for hospitals. http://odin.dep.no/shd/sykehusreformen/aktuelt/rapport/030071-990126, 19.02.03

well. Viewed as a planning process, the reform does not seem likely to lead to a change towards market and patient driven hospital care, but looks rather like a rearrangement of responsibilities within a public regime.

Bureaucratic structures and interprofessional conflicts

In this perspective the changes that take place must be seen in the context of an international process of change where justification for the Norwegian reforms bears a strong resemblance to the way in which similar reforms are justified in other countries. The reforms in most countries have as their purpose to gain control in economic and efficiency terms over the modern public hospital under the assumption that this will reduce it's most perennial and difficult political problem: the waiting lists. Although the Norwegian health care sector is supposed to be modern and well funded it has faced efficiency problems during the last years compared to other western countries. The Hospital reform may therefore be considered a general answer to efficiency- and effectiveness problems in the sector.

There is little doubt among policy makers that Norway faces a financial problem in the sector. Health budgets have grown very rapidly, particularly in the period 1997–1999, and they have grown twice as fast as in the rest of the public sector. Norway currently ranks as one of the biggest spenders on health care, measured as a ratio of the gross domestic product (GDP), among OECD countries. Although there has been considerable growth in patient treatment, the size of waiting lists has remained stable and even growing. The period 1990–1999 has seen the number of physicians rise by 50% in terms of man-years, while nursing man-years have risen by 45% in the institutional health service.[5]

The Hospital reform aims in this perspective at creating a modern organization that operates flawlessly in a rational sense. Therefore, the emphasis is likely to be put on a clear delineation of responsibility and power in order to control behavior. In this perspective rules may affect the changes that the Hospital reform aims at achieving in two different ways.

First, the organization theory behind the reform implies that policies are implemented from top down and top-level decisions often tend to be communicated downwards as rules and regulations. One of the problems built into the Hospital reform is that rules may be produced at different levels: by the Ministry, the regional health enterprises and the local health enterprises. The higher up the locus of rule production, the more difficult it is for the regional and local health enterprises to behave rationally in the above sense. Within months after the reform was implemented, health enterprise

[5] Hellandsvik P. Lecture given at the meeting for Deans and Teaching Hospitals in Reykjavik 31 August 2001. Available on internet: http://odin.dep.no/odinarktiv/norsk/dep/shd/2001/eng.

CEOs complained about the number and detailed nature of rules and regulations by which they are supposed to abide, which are produced by the Ministry of Health.

Secondly, although health enterprise managers are provided with the authority to manage their enterprises autonomously, major interest groups within the enterprise may resist managerial initiatives by emphasizing (formally or informally) existing rules and procedures in their daily activities. In the latter case new policies may be reduced to new justifications for existing practices. Regardless of the level at which rules are brought to bear on the Hospital reform, the danger that threatens the reform is that it becomes hostage of existing practices and the established structures on which such practices are based.

The bureaucratic processes seem to contribute to a rearranging of responsibilities within a health care system dominated by the tension between levels of government and between bureaucratic structures and professionals. It is in this context difficult to discern any move towards market driven competition and patient influence.

Responsibility and «the blame game»

It has been pointed out that «the health gap» – the ever-increasing discrepancy between treatment opportunities made possible by developments in medical technology and research, and the funding at hand to make these opportunities available to the population – in many ways constitute the basic policy problem in health care (Saltman et al 1998, Lian 2003:36). The «health gap» is however not recognized officially as a policy problem. It is typically portrayed as a «question of priorities». The public debate concerning waiting lists demonstrates how the health gap is transformed into an efficiency and priority problem. A possible interpretation of the reform is therefore that it tries to transfer the problem to the individual hospitals and avoid the intractable policy problem caused by «the health gap». To the extent that this kind of motivation drives the process, politicians easily become engaged in a political «blame game» where the core question turns on who is to blame for «the health gap».

The Hospital reform may thus be understood as a response to the nature of politics in the sector. If one considers the Hospital reform in the light of previous reforms, one may argue that the major problem has been the tendency of reform policies to become entangled in political games in a sector where many well-organized and resourceful actors permanently struggle for their interests. Reform policies therefore tend to be of secondary importance and subordinated the interest struggle. In order to better understand the nature of the political games, we shall briefly sum up the recent history of reforms in the specialist health service.

Already in 1974 five health regions were introduced to reflect the fact that as far as specialist medicine was concerned, a large catchment area was needed in order to secure high-quality services at an acceptable cost (St.meld. nr 9 1974–1975). This was the first step in moving the planning function from the county councils to larger regional entities comprising several counties. The five new health regions did not constitute a new administrative level, but their establishment meant that the 19 county councils henceforth were obliged to cooperate within their respective regions.

The next step in transferring influence from the county council level was taken with the introduction of activity based-funding (also called flexible budget) in 1997. As a consequence the power of the county councils to make priorities in terms of budget decisions as well as keeping over all cost control was removed. This made cost control even more problematic. In order to handle the situation the county councils used waiting lists as buffers when costs became too high. The popular legitimacy of county councils as health care policy makers was therefore called into question. Consequently county councils often lost the «blame game», as they were held responsible for tight budget frames as well as cost overruns (total cost control), but had no authority to straighten out their own problems.

The hospitals on their part tried to cope by pressuring the central government for more resources. Activity based funding made it legitimate for hospitals to demand increased funding in order to boost production and reduce waiting lists. The central government was almost unable to turn down requests for extra resources, because they did not know how to justify such a refusal. One reason was the fact that they did not know how to determine the causes of the hospitals´ needs; whether they were caused by inefficiency, increased patient load, or mistakes related to activity accounting (the use of DRG-points) or other reasons.[6]

The problem faced by county councils was exacerbated by the fact that modern hospitals are strongly influenced from bottom up by highly qualified and powerful professions who tend to struggle for resources in order to expand and improve their services. Whether one interprets the struggle as an altruistic struggle on behalf of patients or as selfish interest group activity, the fact remains that influence exerted by professions tends to make hospitals difficult to manage (Berg 1987, Bleiklie 1997, Erichsen 1996, Østergren and Sahlin-Andersson 1998). In many cases professionals operated as independent policy makers who actively tried to influence the priorities of county politicians by attacking hospital managers in public or pressuring them to pleading with the central government for more funding. Hospital managers sometimes learned about the latest initiatives taken by hospital professionals in the media, and felt compelled to respond to such initiatives because of media exposure rather than as a consequence of well-considered plans.

As indicated above, the legitimate authority of the county councils as well-qualified hospital owners had become seriously impaired. The rules of the game that used to form the basis for county council ownership and operational responsibility were no longer present. Both central government policies as well as the maneuvering of professions aided by mass media, had undermined the basis for county council responsibility, and by implementing the Hospital reform the process came to a logical end. After introducing reforms that rendered county councils ineffective as hospital owners, the central government took over and assumed the responsibility. However,

[6] In the years 1997–2002, the government allocated extra funding to the hospitals four times. The arguments they used were 1) a difficult economic situation due to physicians' increased salaries, 2) increased production, 3) a difficult situation for the regional hospitals and 4) increased production and compensation for economic problems related to the transformation to regional health enterprises (St.prp. nr 83 (1996–1997), St.prp. nr. 47 (1999–2000), Innst.S. nr. 241 (1999–2000), St.prp. nr 22 (2001–2002), St.prp. nr 59 (2001–2002), Innst.S. nr. 243 (2001–2002).

introducing state ownership in the hospital sector was not necessarily a logical response to the inefficiency problems in the hospital sector. It was rather a consequence of the fact that the county councils had lost their legitimacy as hospital owners and were thus no longer seen as a viable alternative.

Will the Hospital reform make it possible to avoid «the blame game» in which powerful public pressures generated by strong interests and high expectations combine with unclear responsibilities to create an atmosphere where actors put much energy into avoiding responsibility and fingering scapegoats? Does the introduction of regional health enterprises and state ownership make it more likely that the energy that has been dedicated to «blame games» now will be redirected to problem solving instead? No doubt, a regime change has taken place. The power of professional communities and the dynamics of interprofessional struggle seem to have been replaced by hospital managers, and a professional–political regime has thus been replaced by a political–managerial one.

Previous research demonstrates that changed ownership does not create an efficient and effective organization by itself (Sørensen and Dalen 2001, Kaarbøe and Kjerstad 2001). The usual rationale for central government ownership is that it takes the needs of society into consideration in a sector where the market does not work or does not exist. The assumption is that publicly owned enterprises make it possible to produce public goods efficiently and effectively. Yet if true, the assumption implies that the same goal might have been achieved under the previous owner provided that the county councils enjoyed the authority and legitimacy that is required. A condition for generating change by state ownership is that the central authorities behave differently from the county councils. Otherwise the new health enterprises will end up in the same situation as the county councils. Therefore the expectation that comes with the reform is that the state has to be a more active owner than the county councils used to be.

What this general prescription may entail in practice is highly ambiguous. If state ownership is emphasized, the implication is that the state needs to be an active owner who is prepared to impose its will on the health enterprises. If the introduction of the enterprise form of hospital organization is emphasized, then the state needs to give the health enterprises more freedom to manage their affairs as they see fit. Thus the specific reform may be regarded both as an attempt to become an active owner as well as an attempt at government abdication. The idea is to decentralize authority to hospitals in order to make it easier for them to adapt to their environment. However, decentralization is a complex process fraught with tensions. Firstly, decentralization of public services turns on responsibility as well as on power. Decentralizing the former has proven easier than decentralizing the latter. This may leave the regional health enterprises and the individual health enterprises under them, in a situation that is similar to the one experienced by county councils and hospital managers previously: Health enterprises and regional enterprises are left with responsibility but without sufficient legal and financial means to deal with the problems for which they are held responsible.

If this turns out to be the case, the central government may soon find itself in the familiar situation of having to bail out health enterprises from problems they have been forced to try deal with, but are unable to solve. One case in point is the fact that regional health enterprises by law are prevented from going into voluntary liquidation. This may pave the way for a continuation of the «blame game», but this time with a new

set of actors, the regional health enterprises and the state, as main contenders. To what extent professional groups may still enter the game is an open question and depends at least to some extent on whether local health enterprises will be more effective than hospitals at disciplining their employees. Impressionistic evidence from the latter half of 2003 suggests that this is what has happened: Regime change has taken place in the sense that new actors have become powerful in the hospital sector, whereas the previous power holders seem to fade away. However, politics within the sector seem to remain the same. Health enterprise CEOs now seem to be playing the game with the Health Ministry as adversary. Meanwhile the previous actors seem to have been sidelined. Whereas County Counties simply have been stripped of their previous responsibilities, the professions have become silenced or at least less visible in public policy controversies. If these preliminary observations turn out to be valid, then we have had a successful regime change, but one that has not affected the policy problem that regime change was supposed to solve.

Higher education in the mold

Compared to previous higher education reforms, the Quality reform has been the object of a relatively high degree of interest from political parties. Below we shall try to indicate some possible developments of the Quality Reform process. We shall furthermore present some interpretations of the reform, concerning what it is about and what are the central issues for those who are responsible for the implementation of the reform.

The Quality reform as a planning device

The Quality Reform may be conceived as *rational planning* brought about by a response to specific problems in higher education where politicians aided by experts have formulated policy goals and selected means that shall bring Norwegian higher education and basic research up from a mediocre level into the ranks of the leading nations of knowledge in the world. This is a perspective that has been expressed in statements by politicians and promoters of the reform. Considering how the quality reform has been formulated it may be interpreted as an attempt to achieve a higher degree of efficiency through devolution of authority to the institutions, stronger leadership, increased emphasis on internationalization and a funding model that is supposed to provide incentives for improvement. The content of the reform is in this perspective a direct product of the ambitions of politicians.

The outcome of the reform depends on the resources that are put into the effort and how well adapted the ends are to the stated goals. The funding model is important in this connection. The model consists of three different components: Firstly, there is a basic grant of about 60% of today's budgets. Furthermore about 25% is supposed to be a reward for teaching performance based on the production of credits, candidates and international student exchange. Finally about 15% is supposed to consist of incentives

related to research performance based on the proportion of academic staff that has associate professor level qualifications and the influx of external research funds.

The model has been criticized for two reasons. Partly it has been accused of encouraging institutions to lower standards in order to produce 'successful' students. Partly it has been said to encourage teaching at the expense of research. The process has been characterized by disagreement about leadership and organization principles, and the discussion has to some extent followed the classic pattern of exchanges between 'traditionalists' and 'modernizers'. None of the specific proposals have won general acceptance, and whereas traditionalists argue that the institutions better protect university autonomy against the state and the market if they retain their status as civil service agencies, modernizers insist that the institutions will gain a level of autonomy they have not enjoyed previously if they are organized as public enterprises. This latter question moved into center stage of the public controversy that surfaced during the summer of 2003 and that led to the establishment of «Vox Academica». However, there are no indications that the opposition is planning any kind of resistance beyond exercising pressure on decision makers by keeping the controversy alive.

Less open controversy has surfaced in the discussion over leadership models, but the underlying controversy is similar to the one quoted above. How far should the institutions go in imitating real or perceived characteristics of business enterprises? Regardless which solutions are chosen, power is to be taken from collegial bodies dominated by academic staff and transferred to leaders and executive boards. The choice between the models implies differences regarding the extent of the transfer of power and considerable ambiguity regarding in which direction power is moving and as to who may be likely power holders in the future. The public enterprise model is presented by its supporters as one that will strengthen institutions and enable them to act strategically and flexibly in the emerging market environment for higher education and research. Its opponents on the other hand, argue that it opens up universities to more direct interference from the Ministry as well as from market forces that are detrimental to the freedom of teaching and research.

Impressionistic data from interviews at one Norwegian university indicate overall support of the reform aims and in particular the major changes suggested by the proposed study program reform. This bodes well for reform ambitions. Among faculty the perception that change is needed was a dominant one, and few expressed opinions indicating the likelihood of open resistance or subversive behavior, like the window-dressing or foot dragging that have been observed in connection with previous reforms (Bleiklie et al. 2000). Their enthusiasm with the proposals was, however dampened by the disillusionment with inadequate funding, particularly among university and faculty leaders and some faculty. Their perception was that increased funding, which all actors seemed to agree on in the parliamentary stage of the reform process, had not been provided by the government in the implementation stage. Their response to this situation was that they wanted to comply as far as possible under whatever constraints they might face. However, with the budget proposal for 2004, these concerns seem to have been reduced. Surprising little defense of existing arrangements or subversive or cynical attitudes because of the perceived lack of resources were expressed. These attitudes bode well for the change that the Quality Reform seeks to achieve.

However, if the reform is interpreted as a planned response to a quality problem caused by mediocre teaching and research performance in an international perspective, it has been argued against the reform that it is difficult to see a clear link between the goals and the means that are applied. Both the funding model and the apparently limited resources that have been dedicated compared to what politicians and the higher education institutions apparently agreed on were necessary in the parliamentary phase, may threaten the reform understood as rational problem solving. Again it seems that at least the latter of these concerns has been taken seriously by the government.

One reason for the insecurity surrounding the reform may be that it operates with an ambiguous quality concept. As has been pointed out by Charlton and Andras (2003) in the case of higher education reform in the UK, the quality concept that was introduced with modern quality management audit systems was directed towards enforcing minimum standards and predictable outcomes. It distinguished in a binary fashion between outcomes that fail to meet the standards and those that 'pass' in order to deliver a consistent product. Much of the rhetoric in higher education policy and in academic institutions in the UK presumed that quality was about continuous improvement of academic standards and that outcomes could be arranged hierarchically from 'excellent' to 'poor'. In a rapidly expanding higher education system that was progressively less selective and over time reduced unit costs, quality management systems were important to prevent that the planned reduction in standards fall below a minimum level. Since much of the implementation and detailing of the quality systems were left to higher education institutions and academics, these double and partly directly opposite standards were built into the system and produced a particular mix of dishonesty and confusion that led to the failure of the Quality Assurance Agency. The analysis of the Norwegian Quality Reform should be open to the possibility that similar ambiguity is built into the reform and look for possible implications thereof.

Other aspects of the reform process might on the other hand, facilitate rational planning and predictable reform outcomes. The impression of wide shared support of the reform objectives indicate that conditions are favorable for developing viable settlements that combine fundamental change and are accepted by major interest groups during the reform process. Judging from historical experience, outside events such as economic downturns, may support reform. Interestingly the study program reform is a product of the Bologna-process which caught up with and affected the domestic work of the Mjøs Commission. Rising unemployment may increase funding for higher education and «solve» current funding problems, if the tradition of using the higher education system as an instrument for labor market regulation persists.

Rule following in Academia

A second possibility is to consider the Quality reform as part of *a bureaucratic* process in which changes come about gradually, almost imperceptibly in long term processes of institutional change – revolution in slow motion (Olsen 1983) – in which comprehensive reform proposals in the 1970s, 1990s and the Quality reform gradually are introduced, adapted and polished and take their place as symbolic monuments in

what amounts to a gradual process of change. In this perspective the changes that take place must be seen in the context of an international process of change where the justification for the Norwegian reforms bears a strong resemblance to the way in which similar reforms are justified in other countries. The reforms in most countries form part of a long-term strategy with to main purposes. One purpose is to gain control in economic and efficiency terms over the modern mass systems of higher education that have emerged. The second purpose is to organize and manage institutions in ways that fit current ideas about how large organizations ought to be managed and organized (Meyer and Rowan 1977). In this perspective the ability of institutional leaders to develop long-term strategies is important. In order to have a realistic appraisal of their own limitations and possibilities as leaders they ought to understand how ambitious reforms like the Quality reform find their place in history as small steps in the long term process of institutional change.

One way in which reform processes may fall prey to bureaucratic or institutional inertia is the tendency to use existing procedures and established rules of thumb as a measuring rod in order to determine how much change a reform implies. The reform will accordingly tend to be adapted to existing practices. An important institutional characteristic in this connection is the way in which the prevailing understanding of university autonomy and academic autonomy has interfered with university reforms. Usually reforms have been introduced with some sort of reciprocal understanding that they should be implemented in ways that are acceptable to the academic staff. As long as the basic purpose of the reform is served, one may implement the reform in a way that suits local or even individual preferences and practices. Reform policies therefore have been consensus oriented and tended to imply little change.

Although there seems to be a general support of the intentions of the Quality reform, several actors we interviewed voiced concerns indicating that there may be many reasons why one should stick to old practices rather than adopt new ones mandated by the reform. First, based on the resources argument some held that reform by itself was just a formal structure and that changed practices within the new structures at least in part depended on fresh resources. Secondly in connection with the introduction of new leadership forms some actors held that academics in their own department preferred the traditional collegial model, which they would continue to practice regardless of the formal arrangements that might be implemented

Higher education and the efficiency game

A final possibility is that the Quality reform becomes driven by a *political game* that in this case is likely to resemble an institutionalized ritual. If one considers the reform in the context of previous major university reforms, the reforms of the late 1960s and early 1970s (based on the proposals of the Ottosen commission) and those of the late 1980s and early 1990s (based on the proposals of the Hernes commission), one may argue that they have all tried to come to grips with an efficiency problem.

This problem, which expresses itself in terms of high drop out rates and low credit production, is primarily located in the free faculties at the universities. The eternal

problem of the free faculties in Norway is that they have been open to anyone who generally qualifies as a student and has a high school diploma. These faculties have no control of the number of students they are supposed to serve and are therefore unable to regulate the balance between demand for and available resources. They are therefore victims of circumstances they cannot control. Quality concepts, teaching programs and credit production are products of these circumstances, and the conditions for conscious quality improvement are far from ideal. Authorities are on the one hand under a certain pressure to do something about these problems, yet they are unable or unwilling to do something about the fundamental problem. To deal with the fundamental problem they would either have to dedicate the funding that is necessary or to grant institutions the freedom to regulate the demand for resources by regulating student admission.

From time to time the authorities take action in order to address the problem by means of efficiency rituals that do not deal with the operating conditions at the core of the problem. There is therefore little reason to wonder why there are no well-developed connections between what politicians say they want to accomplish and the means they are willing to dedicate to the purpose. When the Quality reform has been implemented and taken its course we may all lean back and wait for the next major reform. This is a rather more skeptical and pessimistic perspective. It directs our attention to established norms and habitual ways of action that are hard to change and not always easily recognizable. In this perspective leaders may easily become victims of circumstances, squeezed between the expectations of politicians and the public at large of strong and competent leadership and the actual working conditions that provide very limited possibilities to exercise leadership. The admission question is likely to be profoundly affected by the introduction of a course credit system, because it moves the admission question from faculties and departments to study programs. However, the implications are still not clear and university administrators are not ready to answer unequivocally the question of whether open admission still exists or not.

Let us now return to the funding model and point at some of the consequences that may follow if it is implemented as proposed by the government. We will discuss these consequences in the light of the clear reform goal that students are supposed to be successful. Whereas some courses and study programs are easily filled with students who compete for admission, others are not in a position to impose entrance requirements. Among the latter type of programs which are likely to be located in the traditional free faculties, there is also a relatively high likelihood that academic staff will have few means by which they can demand anything from the students in terms of paper writing or participation in classes. The implication of the Quality Reform is that in order to reach its goals demands for improvement are exclusively put on the institution and the academic staff. However, given the operating conditions we have described, one of the few options the free faculties will have to improve their budgets is to adapt standards and quality requirements to student performance. If the reform is interpreted as rational problem solving it is difficult to see how the politicians' ambitions about higher quality are supported by incentives that under the given circumstances invite academics to lower the quality requirements directed at student performance. Yet if one interprets the reform as a ritual that is less binding in terms of political action, this behavior may be explained as the outcome of a complex political game where actions

are not necessarily motivated by goals of the reform, but by immediate concerns of improving support for government policies in parliament or in the electorate.

These pitfalls notwithstanding, the study program reform will to varying extent directly affect the basic process of teaching and quite possibly indirectly affect the conditions for research. According to our preliminary data the reform is thus quite likely to have an impact, quite possibly result in higher efficiency and, given the 2004 level of funding, and better quality. However, it is still an open question what will happen to the proposed regime change, both regarding the formal status of the institutions and the leadership and management models that will be chosen. On the one hand professional influence has been weakened if one looks at representation on institutional boards. On the other hand, other reforms are still not determined. We have therefore seen a movement from a political professional regime towards a stronger administration and a move towards stronger influence by the state and administrative bodies and a political–administrative regime. To what extent the regime has been changed is, however still an open question. We might therefore in this case quite possible see a reform where the new regime that was supposed to generate changed policy content is not established, whereas the policy changes nonetheless will be implemented.

Conclusion – Regime Change as a Condition for Policy Change

We have analyzed the two reforms as political moves aiming at regime change. It seems quite clear which parties – the professional communities – are losing power, but it is not equally clear by whom it is gained although there are some strong contenders. The question still remains of what will be the outcome of the two reforms and if they will become successes or failures. Several authors have argued that it is far from clear what will be the outcome of this kind of reform processes (Bleiklie and Byrkjeflot 2002, Nowotny et al. 2001). Different institutions may face the same reform with different strategies, and different disciplines are affected in very diverse ways by what is apparently the same reform.

One key development in both sectors is the push by government authorities to make the sectors more competitive by means of incentive systems that reward efficient services for patients and clients. Thus we may be heading towards what we may call *a competitive regime* (Byrkjeflot and Neby 2003), characterized by a government push towards a quasi-market dominated by consumer driven arenas and political hierarchies. If the reforms result in the intended regime change, the next question is what this may entail for the services that are provided by hospitals and higher education institutions. However, our analyses so far, indicate that the push towards a competitive regime may be severely dampened by a stronger push for more state control. If this is correct we may be seeing a move towards stronger *political–administrative regimes*. This means that both the hospital sector and the higher education sector are moving away from *political–professional regimes* in which professional communities and political hierarchies are

predominant towards a regime where both the state and the market actors (or models) may play stronger roles.

Our observations indicate that there is a number of interesting differences between the two sectors which make a comparison of interest. Both reforms have similar objectives: strengthen management and provide more customer friendly services. Yet the emphasis is different. The hospital reform is primarily a structural reform aiming at creating more clearly defined responsibilities between the hospital owner and funding source, the state, and those in charge of running them, the regional and local health enterprises. The higher education reform is a broader reform that both interfere directly with the basic work processes within institutions (in particular the teaching function) and with the structural organization of state-institution relationship and internal governance structures.

First considered from a planning perspective, there are a number of paradoxes built into both reforms: Both are explicitly aiming at meeting efficiency requirements and customer preferences in ways that are clearly contradictory if one tries to meet both goals with respect to the same set of services at the same time. The Hospital reform plans the activities of hospitals, but does not consider their relations with primary care. Furthermore it tries to combine the creation of monopolies with competition. The quality reform is unclear about the concept of quality which may be aiming at excellence at the rhetorical level, but in its instrumental aspects, such as the funding model, seems to be opting for a minimum quality standard.

The hospital sector seems to have a history that is more clearly characterized by conflicts and interest struggle, and a focus on working arrangements. The reform process so far has started to exhibit signs which may demonstrate that such conflicts are not easily removed by regime change. This may indicate that although a regime change has taken place that has enhanced the legitimacy of hospital leadership and enabled management to effectively keep internal conflicts out of public view. However public conflicts still emerge and the blame game seems to continue, but with new actors as the main contenders. In the higher education sector evidence of conflict is also clear. In this case it was, in a way that is consistent with prevailing traditions of the sector, characterized by a media controversy about the formal status of higher education institutions as civil service agencies or public enterprises. This means that major policy changes may be implemented without problem, whereas regime change is contested. However, it is rather surprising that university professors seem to expect that they will have to teach more and accordingly do less research without openly protesting. In general they seemed to be in favor of the study program reform. Two mechanisms may explain this lack of opposition. They may still have hoped for a substantially increased funding lever that will keep the teaching load constant at the individual level. Their hopes seem for now to have been vindicated. Alternatively, they may expect that they will have the opportunity to work things out independently in a way that will allow them to work more or less like before. This means the professors expected that established patterns to prevail and that they still would have sufficient autonomy to sustain established work practices and avoid heavier teaching loads.

This brings us to the question of the effect of bureaucratic structures and rule following. Whereas the possibility that institutionalized practices might contribute to

slowing down or diverting the reform processes are definitely possibilities in both sectors, there are clear differences with respect to what we have actually observed. In the hospital sector the main bureaucratic obstacles to the reform process stem much more clearly from the traditional way the new owner via the Health ministry manages hospitals, via rule production and directives, and from rule production at multiple levels. In the health sector it is more likely that bureaucratic obstacles are used by members of the basic organizational units to limit the impact of unwanted reforms in a bottom up process.

Both sectors have been the subject to reforms where regime changes where combined with new policies in order to improve quality and efficiency to better serve patients and students. The basic idea in both cases was that regime change should promote new policy content. While it is important to emphasize that the evidence we have presented is limited and that our assumptions are preliminary, the evidence suggests that the relationship between regime characteristics and policy content is quite loose. Whereas the hospital sector seems to experience regime change without (significant) policy change, the higher education sector may be headed for policy change without regime change.

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